DOCUMENT RESUME

ED 216 012 TM 820 094

AUTHOR Meehan, Merrill L.
TITLE Third year Evaluation of a Model Home-Based Program for Severely Orthopedically Impaired/Mentally Retarded Children & Youth.
INSTITUTION Appalachia Educational Lab., Charleston, W. Va.
SPONS AGENCY Bureau of Education for the Handicapped (DHEW/OE), Washington, D.C.
PUB DATE Sep 80
CONTRACT 300-77-045
NOTE 135p.

EDRS PRICE MF01/PC06 Plus Postage.
DESCRIPTORS Daily Living Skills; Elementary Education; Elementary School Students; *Home Programs; *Individualized Instruction; Medical Care Evaluation; *Mental Retardation; Normalization (Handicapped); *Parent Participation; *Special Education
IDENTIFIERS *TARC Assessment System

ABSTRACT

The Orthopedic Homebound Program was meant to prevent the institutionalization of orthopedically impaired, mentally retarded children and to involve parents in their training. The program was proposed and managed by the Shawnee Hills Community Mental Health/Mental Retardation Center in rural West Virginia. Each child's developmental needs were assessed by an interdisciplinary team of psychologists, social workers and therapists to determine an individualized plan of behavioral objectives to be carried out by home trainers and parents. Progress was measured in part by the TARC Assessment Inventory for Severely Handicapped Children. Interviews of parents assessed their interaction and expectations for progress, as well as their evaluation of the program. The parent/home environment was evaluated by home workers. Major program support components included: (1) quarterly inhouse reports, (2) a monthly newsletter and (3) a handbook for parents, (4) regional and national conferences, and (5) a concluding seminar for parents and program personnel to discuss process and product effectiveness. Data tables, references and 13 appendices of program material, publication samples and evaluation instruments are provided. (CM)

...tally ...dren

SCOPE OF INTEREST NOTICE

The ERIC Facility has assigned this document for processing to TM | EC

In our judgement, this document is also of interest to the clearinghouses noted to the right. Indexing should reflect their special points of view.

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

- [X] This document has been reproduced as received from the person or orgaoization onginating it
- [ ] Minor changes have been made to improve reproduction quality

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy

The Appalachia Educational Laboratory (AEL) is located in Charleston, West Virginia. Its mission is to improve education and educational opportunity for persons who live in the primarily non-urban areas of its member-state Region. AEL accomplishes its mission by:

- documenting educational problems of the Region and sharing the information both with member states and other R & D producers;
- identifying R & D products potentially useful for solving the documented problems and sharing information about these with member states;
- providing R & D technical assistance and training, which may include adapting existing R & D products, to lessen documented problems of the Region; and
- continuing to produce R & D projects of national significance in the areas of career guidance, childhood and parenting, experiential education, and others that may be identified.

APPALACHIA EDUCATIONAL LABORATORY
(Attn: Sevilla Finley)
Resource & Referral Center
P.O. Box 1348
Charleston, West Virginia 25325

Third Year Evaluation of a Model Home-Based Program for Severely Orthopedically Impaired/Mentally Retarded Children & Youth

by
Merrill L. Meehan

EDUCATIONAL SERVICES OFFICE

September 1980

Appalachia Educational Laboratory
Post Office Box 1348
Charleston, West Virginia 25325

The project presented or reported herein was performed pursuant to one or more contracts and/or grants from the U.S. Office of Education, Department of Health, Education, and Welfare. However, the opinions expressed herein do not necessarily reflect the position or policy of the Appalachia Educational Laboratory or the Department of Health, Education, and Welfare, and no official endorsement by the Appalachia Educational Laboratory or the Department of Health, Education, and Welfare should be inferred.

TABLE OF CONTENTS

APPENDICES

LIST OF TABLES

CHAPTER I

Executive Summary

Background

The Orthopedic Homebound Program (OHP) was a project proposed, managed and operated by the Shawnee Hills Community Mental Health/Mental Retardation Center, Inc., Charleston, West Virginia. It was a three-year model project funded by the Bureau of Education for the Handicapped, U.S. Office of Education. The purpose of the project was to prevent the institutionalization of the orthopedically impaired, mentally retarded children and youth in the four county service area. These four counties are primarily rural and, thus, the project was conducted in the clients' homes.

Upon client enrollment in the program, an interdisciplinary team of professionals visited the home and conducted a client evaluation/diagnosis "clinic". Based on data and recommendations from the "clinic," an individual program plan (IPP) was developed for the client. The IPP was implemented by the home trainer. Parents were instructed on how to implement the IPP between home trainer visits and after the OHP concluded.

The Appalachia Educational Laboratory (AEL) subcontracted to conduct the third party evaluation for each of the project's three years. The evaluation was organized on the basis of: (1) client progress, (2) the parent component, and (3) the various ancillary components of the program.

Results - Clients

By the end of the second year the TARC Assessment Inventory for Severely Handicapped Children (Sailor and Mix) was administered at least once to ten clients. One child was assessed as "profoundly" retarded, four as "severely" retarded, and five as "moderately" retarded. Of the five clients for whom there were at least two TARC profiles, four made gains. There were net gains in the two areas of self-help and motor, and net losses in the two areas of communication and social. Inspection of the individual program plans revealed the areas in which the clients gained the most were, by far, the areas most strongly emphasized in the homebound program curriculum. Only three of the five clients who had at least two TARC scores during the second year remained through the third program year. Although all three clients did show overall gains (with most progress made in social development) it is not possible to make generalizations about program effectiveness.

Results - Parents

AEL conducted an assessment of parent attitudes and skills. A parent interview schedule and a parent/home environment evaluation form were the data collection devices. Four dimemsions were measured by the two devices. First, most parents' expectations for their child changed

dramatically over the course of the project: the changes were from global, unrealistic expectations to more program-specific objectives. For example, one mother who said she would like to see her son "walk and talk" when interviewed at the end of the first year expected that "he may grasp something with his left hand and maybe notice things more" when interviewed at the close of the project. Second, based on parents' narratives of a typical day, it was found that eight out of nine parents interacted with their child in a teaching/learning mode. The amount of time for such activities per household ranged from 10 to 35 percent of the time. Third, on the basis of interviews, it can be said that eight of the nine families who participated in the OHP have strong family support systems. Indicators of this include: parents or in-laws live close by, married children visit regularly, and aunts and uncles live in the vicinity. Fourth, when asked to evaluate the homebound program, parents gave strongly positive comments. It was clear that parents think the OHP benefited not only their children but also themselves. Parents cited specific examples of ways they have learned to handle, feed, and teach their children. When asked, seven of nine parents said there wasn't anything about the program they didn't like.

Results - Program Components

Five major program components, which were supportive of the client and parent activities, were evaluated by AEL. First, three quarterly, inhouse reports were analyzed. Data contained in the reports showed that 26 major, different OHP staff activities were completed. Data displayed in the full table and summary table revealed that the OHP served a low number of clients but with a very high number of direct client services including home trainer visits. Also, OHP staff reported they exceeded the host agency's targets for: (1) public education activities, (2) direct services to clients, and (3) staff development hours. Second, the program's "Orthopedic Homebound Monthly Newsletter" was a very successful activity. Parents rated it high in quality, they liked it, most read the whole issue and found useful information in it, and the majority saved the newsletters. More importantly, all but one parent said they performed suggested activities in the newsletter with their child. Third, a first draft of a handbook written for parents of severely impaired/mentally retarded children and youth was evaluated by ten special educators. The overall rating of the parent handbook was between average and high value. Reviewers provided well thought out responses including numerous suggestions for improvement of the draft version of the parent handbook. Fourth, the OHP presentations made at one regional and three national conferences were received well by session participants. All OHP presentation components and the overall presentation ratings were high and consistent. Forty out of forty-two respondents named one strength of the presentation with the slide-tape show being the clear-cut favorite. Fifth, a day and one half culminating seminar designed to bring together parents and professionals interested in services for the severely handicapped to discuss processes and products regarding topics of lasting concern once the project concluded was evaluated by AEL. The overall rating of the whole seminar was relatively high. Interestingly, the highest rated session was a presentation made by a mother of a severely mentally retarded son.

CHAPTER II

Client Progress

Introduction

A Model Home-Based Program for Severely Orthopedically Impaired/Mentally Retarded Children and Youth was a project funded by the Bureau of Education for the Handicapped, U.S. Office of Education. Its contract number was 300-77-045. The project was proposed, managed, and operated by the Shawnee Hills Community Mental Health/Mental Retardation Center, Inc., (hereafter simply Shawnee Hills), Charleston, West Virginia. The name of the project within the Shawnee Hills Agency itself was Orthopedic Home-bound Program (OHP) and, thus, for the sake of convenience, this will be the project's name throughout this report.

The philosophy of the program, as gleaned from project proposals and reports, was to prevent the institutionalization of orthopedically impaired, mentally retarded children and youth in the Shawnee Hills service area in West Virginia. The OHP served Boone, Kanawha, Putnam, and Clay counties. This Region is primarily rural with the single exception in the greater Charleston area. Additionally, the program strived to provide service-area retarded clients with an as much like normal life-style as possible.

Shawnee Hills believes that mentally retarded individuals should live and function in an environment that is as "normal" as is possible, and, thus, those school-age individuals who can do so participate in a public school or center-based program. Because of this philosophy, rigorous requirements and an effective screening process have been operationalized for placing clients. Only those clients not able to be placed in either a

public school setting or any one of the other Shawnee Hills Center's programs are included in the homebound-type program. The project provided direct intervention and educational training for each client with emphasis placed on parental involvement.

The OHP began in July, 1977, and continued for 36 months, ending in June, 1980. The OHP has had a third party evaluation component since its inception. The Appalachia Educational Laboratory, Inc., (AEL) Charleston, West Virginia conducted the first and second year evaluations. Reports of these two previous evaluation reports have been submitted to the Shawnee Hills agency. The purpose of this report is to display data and provide narrative copy resulting from the third year evaluation of the Shawnee Hills OHP. AEL again conducted the evaluation. This evaluation report is organized into three major sections which focus, respectively, on: (1) client progress, (2) evaluation of the parent component, and (3) evaluation of the various ancillary components of the program.

Client Evaluation: The Team Approach

In a program which serves children with special educational needs, the one question most frequently asked is: "Does it work?", i.e. "Is it promoting development such that the outcome is improved client functioning?" or, "Is it preventing the institutionalization of mentally retarded persons?" In order to make such a determination, one needs to look first at the clients' levels of functioning upon enrollment, the goals and specific objectives established for each client, and the levels of functioning after participation in such a program.

Because each child enrolled in the Orthopedic Homebound Program requires extensive evaluation by a number of different professionals, the

interdisciplanary team approach is used. Team members include the following: social worker, nurse, special educator (Client Program Coordinator), physical therapist, occupational therapist, speech pathologist, and psychologist. A home trainer and the child's parents also are members of the team and, although they perhaps do no formal assessments, they bring to the team valuable information regarding the child's "at-home" typical behaviors, his or her disposition, and the child's likes or dislikes.

A major accomplishment during the first year of program operation was the recruitment of staff and the development of procedures to conduct the various evaluations, coordinate the results, and establish meaningful objectives for individual clients with periodic review of these objectives by team members. This process has been refined continually during the second and third years.

Upon client enrollment, the program team visits the home and conducts a "clinic" which consists of evaluations including, but are not limited to, the following:

1. Social history: This includes the diagnosis (e.g., "cerebral palsy, atheto-spastic; severe mental retaration; severe speech impairment/delays; strabismus"); a medical history; a narrative on the child's family/physical environment; primary parental concerns, e.g., financial concerns; and recommendations related to the social welfare of the child and the family.

2. Medical: The parents provide the results of a recent medical examination by a doctor of their choice. The nurse follows up on any complications and provides recommendations to the team regarding health considerations which may affect home treatment, e.g., special diet, medication and any possible side-effects.

3. Developmental/special educational assessment: The Client Program Coordinator (CPC) administers one or more developmental instruments which are, for the most part, observational. During the first year of program operation, a variety of instruments was used, including the P-A-C, the AAMD Adaptive Behavior Scale, the Developmental Record, the Marshalltown Behavioral Developmental Profile, and the Learning Achievement Profile (LAP).

During the second year, the TARC Assessment Inventory for Severely Handicapped Children (Sailor and Mix, 1975) was administered to every client. This measure provides standard scores in the following four developmental areas: self-help, motor, communication, and social. Additionally, it yields a raw score total which can be used to estimate the overall level of retardation or developmental delay.

During the third year, the West Virginia Assessment and Tracking System (WVAATS) was the only instrument used. This instrument assesses skills in 20 areas and is accompanied by curriculum cards in these areas which are matched to a child's performance level.

4. Physical therapist assessment: This is generally a narrative report of the client's motoric involvement which includes specific recommendations to the team regarding gross and fine motor development.

   The physical therapist assesses the client's levels of reflexes, sensory responses, and physical skills. The assessment results in recommendations to the parents regarding their handling of the child and suggestions for exercises which may improve muscle tone and range of motion. The therapist may also recommend certain equipment to aid in posturing the client.

5. Occupational therapist evaluation: The occupational therapist (OT) assesses muscle tone and range of motion, working with the physical therapist to provide recommendations for increasing range of motion through exercises. The OT also assesses reflexes and makes suggestions for positioning the client, sometimes designing and using adaptive devices to prevent muscle breakdown. Recommendations are made for feeding programs, to assist parents in finding ways to decrease unwanted reflexes, and to suggest positioning techniques to alleviate feeding problems. Other recommendations in the area of self-help include: bowel and bladder care, suggestions for transferring the client from a wheelchair into bed, and techniques to encourage more independent dressing.

   The occupational therapist also assesses other physical abnormalities and recommends and prepares splints when necessary. The form which was used for OT evaluation is attached as Appendix A.

6. Speech/communication diagnosis: If the child is able to respond to testing, the speech pathologist administers one or more of the following standardized tests:

   1. Peabody Picture Vocabulary Test
   2. Assessment of Children's Language Comprehension
   3. Preschool Language Inventory
   4. REEL

More typically, however, the speech pathologist uses informal methods of diagnosis because of the clients' limited ability to communicate and their extensive physical involvement.

This informal speech assessment measures the levels of receptive and expressive language, and determines the child's main method of communicating. Some examples of the informal assessment are: observing the child's oral-motor movements, asking the child to identify pictures by function, giving increasingly complex commands, or asking the child to imitate speech sounds. The results of this assessment are written up in a narrative report.

The Individual Program Plan

Based on recommendations from each team member, the CPC prepares an Individual Program Plan (IPP). The IPP specifies behavioral objectives for each client on a daily, quarterly, and yearly basis. Any team member may suggest revisions or additions to the IPP; however, once they have been agreed upon, the stated IPP objectives form the basis for the child's curriculum. The home trainer has the responsibility to implement the program.

The IPPs serve as a good measurement of client progress. For example, a daily objective for one child was: "The child will demonstrate lip closure while eating 10 percent of the time." Once the child achieved that goal, it was restated, "The child will demonstrate lip closure while eating 25 percent of the time," and then was increased to "... 50 percent of the time." (The limitation of this particular objective is that it was not specified on the IPP how the percentage was measured; however, assuming a reliable method of measurement, we can chart measureable client progress over a period of time on the objective.)

At the end of the program's second year, a new curriculum was adopted called the West Virginia System (Cone, circa 1979) which had been

developed through a joint project of the West Virginia University Affiliated Center and the West Virginia Department of Health.

Consequently, most of the specific client objectives on the IPP during the third year were taken from the West Virginia System. These objectives were accompanied by specific activities. Client performance was charted daily by the parent or weekly by the home trainer if the parent was not cooperative in following through and recording the data. Only one parent successfully kept daily records of her son's performance. A sample of the objectives and a completed Universal Data Sheet are included in Appendix B.

Developmental Gains

Results of the TARC: Year Two. Beginning in August, 1978, it was decided that the TARC would be administered to every client upon enrollment and would be repeated at six-month intervals. Although it was recognized that most clients would need additional developmental assessments in order to plan IPPs, the TARC was selected as an instrument with which client progress could be compared both across time for individuals (Client #1 compared with self after six months) and also across development areas for the entire group of clients (Client #1 gains in self-help compared with Client #2 gains in self-help). This across-group comparison was not possible during the first year because different assessments were used for individual clients.

By the end of the second year the TARC had been administered at least once to ten clients. The TARC profile (see Appendix C) yields the following 17 standard scores:

1. Self-help Total
    a. Toileting
    b. Washing

c. Eating
d. Clothing

2. Motor Total

a. Small Muscle
b. Large Muscle
c. Pre-Academic

3. Communication Total

a. Receptive
b. Expressive
c. Pre-Academic

4. Social Total

a. Behavior
b. Pre-Academic

OVERALL TOTAL

The overall total score can be related to degree of retardation. Using the TARC as the indicator, one child was assessed as "profoundly" retarded, four as "severely" retarded, and five as "moderately" retarded. One would expect progress over a period of six months to be inversely related to severity of retardation, i.e., clients with only moderate retardation might be expected to show greater developmental gains than clients with severe or profound retardation.

In addition to degree of retardation, one might expect that age would be an important variable related to developmental gains, i.e., the younger the child, the greater the probability of development. Presumably, older clients have been without services for a greater period of time; consequently, their development would be delayed the furthest. In older clients muscular deterioration will have occurred and possibly be irreversible. Additionally, families who have lived for a long time with a multiply-handicapped child will probably have lower expectations and will have made

adjustments in their life styles to accommodate the client's level of functioning.

Table 1 shows the ages of the clients in 1978-79. Of the five clients for whom there are at least two TARC profiles, three of them are in the oldest range (19-21 years), where one would expect minimal gains. The younger child was also the most profoundly retarded (ID #105).

The chart in Table 2 shows gains (+) and losses (-) at the end of the first six-month testing in which the TARC was used.* Four out of five clients made gains. Looking at the total scores for all four areas of development, there were net gains in two areas: Self-help and Motor; and net losses in two areas: Communication and Social. Although it is difficult to account for the developmental loss, the areas in which the clients gained the most were by far the ones most strongly emphasized in the home-bound program curriculum. One finds few objectives in the IPPs related to communication or social development.

The curricular emphasis on motor skills and self-help skills follows the course of "normal" development in children. At a very early age normal children acquire complex sensorimotor skills which most of the OHP clients lack. Such things as holding their heads up, sitting without support, reaching for an object, and more advanced skills such as crawling, walking, and eye-hand coordination are lacking in most of the program's

---

*The gains and losses are reported as points gained or lost on each scale after six months. One point does not have a consistent value across scales. (See profiles in Appendix C.) For example, one point on the self-help washing scale is the equivalent of five points on the self-help toileting scale, both being equivalent to 15 on the standard scale of 100, were 50 is the mean score. For a more accurate picture of gains made, consult the individual profile charts.

Table 1

Ages of Clients to Whom the TARC Was Administered

TARC Administration	Age in Years				
	6-8	9-12	13-18	19-21	Total
At least one TARC administered	4	X	3	3	10
Withdrew before 6-month testing	2	X	X	X	2
Enrolled recently; no posttest scores available	1	X	2	X	3
Two TARC's administered	1	X	1	3	5

Table 2

Changes in Child Performance on TARC
Over Six (6) Months*

Client I.D.	TARC Categories																
	Self-Help					Motor				Communication				Social			Raw Total
	Toileting	Washing	Eating	Clothing	Total	Small Muscle	Large Muscle	Pre-Academic	Total	Receptive	Expressive	Pre-Academic	Total	Behavior	Pre-Academic	Total	
105	0	-1	+2	0	+1	+1	+1	-2	0	0	-1	0	-1	+3	0	+3	+3
113	-1	0	+1	0	0	+3	+2	0	+5	0	0	-1	-1	0	0	0	+4
173	+5	+2	0	+2	+9	+2	+3	-1	+4	0	-1	-3	-4	-5	-2	-7	+2
183	+2	+1	+2	0	+5	+3	+1	+2	+6	0	0	-3	-3	-1	-3	-4	+4
194	0	0	-1	-2	-3	-1	+1	-2	-2	+1	0	-3	-2	-2	-3	-5	-12

*Dates of TARC administration for all (5) clients were 8/28/78 and 3/T5/79.

homebound clients. Children can be trained in self-help skills before (or without) the development of language. The curriculum is developmental; however a more comprehensive curriculum could build on existing communication and social skills. These skills are especially important to older clients, who may be past the point of recovering much in the area of motor development or in self-help skills which require motor skills.

It is clear from the results of the TARC and from individual client progress records that significant progress was made by the clients served during Year Two. In two areas of self-help, for example, one client (#173) advanced from below the mean score to one standard deviation above. It is also important that gains are related to curriculum, which would indicate that the home trainers are effectively carrying out the IPPs. Although the TARC has the advantage of providing comparable data on a standardized instrument, it fails to reflect some of the gains which are made by clients because it is limited to measuring major milestones of development.

Results of the TARC: Year Three. Only three of the five clients who had at least two TARC scores during Year Two remained through the third program year. At program end, for the sake of evaluation, TARCs were completed on these clients.

With so few clients, it is difficult to make generalizations about program effectiveness; however, all three did show overall gains with most of the progress made in social development.

Results of WVAATS. During the third year, the WVAATS was used for all clients for the first time. Of the eight clients served during this last year, only three had two completed assessments (although there was

time for at least three six-month assessments). Consequently, the data yields no information in terms of developmental gains.

CHAPTER III

Parent Evaluation

Parents are a vital part of a home-based program. They fill the role of therapist and teacher, as well as caretaker, by carrying out activities suggested by the home trainer. Parents record daily progress and are important members of the evaluation team which sets objectives for each child. In a home-based program such as this one, parent teaching skills and parent attitudes toward the handicapped client may be important indicators of the probable success of the program in improving the skills and the living conditions of the enrolled clients.

Obviously, parents are important in determining whether or not a child is enrolled in the program. In the first year, seven (7) parents refused services altogether. Other parents are unable to carry out activities suggested by the home trainer. Reasons may include lack of time, lack of motivation, emotional instability, lack of energy, or lack of skills. Home trainers, in some cases, serve not only the enrolled client but also the parent. In order to serve the clients of the Orthopedic Homebound Program (OHP), it is a part of the home trainer's job, with support from the social worker and other staff, to see that social services, medical care, counseling, and basic self-help skills are available to families of their clients.

Development of the Parent Interview

AEL's involvement in the evaluation of the program included an assessment of parent attitudes and skills. During the second year of the program, an interview schedule was developed (Appendix D) and was used on a trial basis to measure parent expectations for the program (to be

conducted after participation). A literature review yielded several instruments designed to measure home environment, parent attitudes, parental evaluation of and participation in home-based programs, and parent attitudes toward developmentally delayed children. None of the existing instruments was appropriate to the Shawnee Hills OHP population because they were designed either for a preschool-aged population or they required extensive administration time on the part of the parent and/or of a trained observer in the home. However, parts of several instruments were adapted and combined into an interview schedule to measure the following variables:

- Parental interaction with the child,
- Quality of environment and stimulation available to the client within the home setting,
- Parental locus of control,
- Parental support system: family accessibility and community participation,
- Parental evaluation of the program and benefits to the child,
- Parental expectations for the child, and
- Limited demographic information, e.g., educational level, income, occupation, number of siblings, and age of parents.

In addition to a parent interview, the instrument included a checklist to be completed by the home trainer. (See Parts I and II, Appendix E.) This was used only once in the middle of the second year of program operation. The instrument was reviewed by the AEL Protection of Human Subjects Committee on December 1, 1978. Several minor revisions were made based on that committee's recommendations, and the instrument was pretested on parents enrolled in the Infant Home Bound Program of Shawnee Hills.

Beginning in January, 1979, AEL staff made home visits to interview parents of enrolled clients; and the home trainer began using the checklists. This was not a true pretest for many clients as they had been enrolled in the program for up to 1 1/2 years. Nine (9) parents agreed to participate in the interview process. The results of the interviews are reported in narrative form to cover: (1) parental evaluation of the home-based program and expectations for their child; (2) parental interaction with the client; (3) parental expectations for children; and (4) parental support systems outside (or inside) the home. The variable "locus of control" did not discriminate between parents and, thus, was eliminated. It was anticipated that all new clients' parents would be interviewed as soon after enrollment as possible during the third year. Due to a late contract approval date, however, AEL's involvement was limited to the last three months of the 1979-80 program year. Consequently, no pretests were obtained. Five parents were interviewed at program end. The following commentary utilizes data from both sets of interviews, a combined total of eleven parents.

Parent Evaluation of the Homebound Program

When asked to evaluate the homebound program, parents gave strongly positive comments. Nine of the parents had been involved in the program long enough to be able to tell what they liked and did not like about it. (See questions 16-21 from Part II; Appendix E.) Parts of their answers to question 16, "What do you like best about the Shawnee Hills Program for your child?" are excerpted below.

- "At least there's someone that will do something for kids like mine. Before this, no one had even told us that she needed to be exercised...and she just lay, ate, and slept...She couldn't even move her arms."

- "I like that they come to the home...help her learn...She has learned so much better."
- "They're learning him how to work with his hands and hold things; learning him letters..."
- "The main thing is the people. I haven't met one I didn't like...[The home trainer] is something special. She's just so good to [my child]."
- "I really like the people...Seems like they're interested."
- "What they wrote up for me to work with him on...The people are real nice; they came to see him in the hospital."

When asked, "What don't you like about the program?", seven of the parents said there wasn't anything they didn't like. One of them wished that home trainers could do the physical therapy exercises, and one mentioned she didn't like the physical therapist (although another mother stated how much she really liked the physical therapist). A similar question, "Do you have any suggestions or ideas for improving the Shawnee Hills program?" brought similar responses. All of the parents were satisfied with the current program. At the end of the second year, two parents wished the home trainers could come more regularly or more often--at least twice a week. However, during the third year, most homes received two weekly visits and no one mentioned this as a problem in the final interview.

The parents were asked, "Do you think the 'home trainer' approach is the most effective method for helping your child?" Only three parents preferred home-based to center-based; the others would have preferred a school or center-based program if one were close enough that their child could attend. Travel distances to the Shawnee Hills Center--some up to three hours by bus one-way--are prohibitive for the children.

It is clear that parents think the program benefits not only their children but also themselves. Question 20 asks if they have benefited or learned anything from involvement in the program. Parents cited specific examples of ways they have learned to handle, feed, and teach their children. Additionally, they felt one of the major benefits was in learning of other parents with children like their own. For example, one mother said, "You realize you're not the only one in the world with this problem ...I ask the home trainer about the other children and what they're like." Another said, "...if ever I was to come across a child like mine, I feel like maybe I could help [the parents]."

Parental Interaction with the Client

It is hypothesized that participation in the homebound program would have an affect on the quantity and quality of parental (and other family member) interaction with the child enrolled because of the program's emphasis on parent involvement in the teaching/learning process. In Part I of the parent evaluation instrument, parents were asked to describe a typical day in their homes by relating the events of the previous day in detail. These narratives then were rated into discrete events which lasted at least five minutes. Each event was categorized into one or more of the following categories: Child Alone; Parent-Child involved in Teaching/Learning (e.g., exercising, talking, playing games, etc.); Parent involved in the care of the child (e.g., toileting, dressing, feeding, etc.); and Child with Other People in passive activities (e.g., watching television).

Of the nine parents interviewed at the end of the second year, six had been enrolled in the program for up to 1 1/2 years. One might have expected that program effects would have been evidenced in these six (6)

families compared to the three (3) newly enrolled clients by more events in the two (2) categories: "Teaching/Learning" and "Child with Other People".

The number of events (and percentage of total events) are presented in Table 3, with the last three clients (#7-9) representing the newly-enrolled clients. There were no major differences between the "older" clients compared to the newly enrolled clients in terms of percentage of time spent interacting with other people. It was anticipated that after the interview had been administered a second time, events could be compared on a pre- and post-test basis. However, only three of the five parents interviewed in the third year were among the nine interviewed previously. Consequently, there is not enough available data to make these comparisons.

Parental Expectations for Children

Although the parents are team members, when asked what they would like to see their child accomplish in the future, they rarely mentioned specific program objectives. After the second program year, three (3) parents expressed a desire for improved speech but quickly added that they felt that was something that would never be achieved; three (3) parents stressed self-help skills or independent living skills; and two (2) parents couldn't name anything that they hoped or expected their child would accomplish.

To obtain a better measure of parental expectation, a question was added to the interview during the third year. This question asked parents what they expected their children will accomplish over the next year. This additional question did seem to provoke more realistic expectations.

Table 3

Number and Percentage of Parental Events by Category

	Clients								
Categories	1	2	3	4	5	6	7	8	9
Parent with child in Teaching/Learning Activities	7 35%	1 10%	4 27%	2 17%	2 20%	0 0%	4 20%	4 21%	6 27%
Child with Other People (Passive)	2 10%	2 20%	4 27%	3 25%	2 20%	1 8%	5 25%	5 26%	7 32%
Parent with Child in care-giving activities	7 35%	3 30%	6 40%	6 50%	4 30%	11 68%	9 45%	6 32%	8 36%
Child Alone	4 20%	4 40%	1 7%	1 8%	3 30%	4 25%	2 10%	4 21%	1 5%
Total	20	10	15	12	11	16	20	19	22

For example, one mother, who would like to see her son "walk, talk, be more normal," expected that he would perhaps "bend his legs slightly" over the next year and "move a little bit more than what he does". Another mother, who also would like to see her son walking and talking, thought that "he may grasp something with his left hand and maybe will notice things more" over the next year.

Question 15, Part II (see Appendix E) asked if the parent has any future plans for his or her child. Three (3) parents had specific plans to send their children to appropriate school placements, when health problems and/or travel arrangements can be made. The other eight (8) parents had no specific plans although two mothers felt they would be able to carry on the activities that the home trainer had established in the IPP. The primary concern of mothers in this regard is what would happen to the child if she became unable to care for him or her. Some of their comments, "How can you make plans? We've been told it's a matter of time." and "We're taking one day at a time." reflect the lack of options available to parents of severely handicapped children. In fact, the reality of future institutional placement was implied, although not verbalized, by most of these parents: it seemed to be an option they avoided discussing. The termination of the homebound program seemed to be just one more setback. They viewed the program as a special privilege, not as a right, and it will be missed sorely. However, most parents do not feel there is much hope for their children to be independent.

Parental Support Systems

On the basis of interview results, it can be said that eight (8) of the nine (9) families who participated in the program have strong family

support systems. (This may be the reason why they are able to cope so well with a severely impaired child and a major contributing factor to the delayed institutionalization of these clients.) In most cases, parents or in-laws live close by, married children visit regularly, and/or aunts and uncles live in the vicinity.

Only four (4) families reported membership or involvement in outside groups or organizations, and two (2) of these had only one outside affiliation (they were church members). The remaining five (5) reported that no family member was involved in any group membership. This seems to present a picture of isolation in any group membership. And, of course, most parents of severely handicapped children are very limited in the time available to them to spend away from home. Of the two (2) families who reported membership, it was not the mother who was active.

The original project proposal suggested that parent groups would be formed by geographical region, whereby parents could share experiences and learn together. This idea was not feasible due to lack of parental availability, small client numbers enrolled, and long travel distances. However, other options were to be explored, such as a parent "buddy" system, or trained baby-sitters to provide relief times. This, too, was not accomplished.

Other agencies do seem to be utilized. Eight (8) parents reported satisfactory involvement with the Crippled Children's Clinic; two (2) were receiving welfare help via medical cards; and two (2) received SSI checks.

One significant client case was reported in the local press. Appendix F is a photocopy of an article appearing in the March 26, 1980 issue of the Daily Mail published in Charleston, West Virginia.

CHAPTER IV

Component Evaluation

Chapter II presented client progress data and Chapter III presented parent evaluation data of the Orthopedic Homebound Program (OHP). This chapter presents evaluation data related to several major components of the program. These program components were, in most cases, supportive of client and parent activities, but are presented in this chapter for ease of understanding by the reader. Following are evaluations of the quarterly reports, parent newsletters, parent handbook, conference presentations, and the culminating seminar.

Quarterly Reports

The program director prepared quarterly reports during the third year. Three such reports were received by the evaluator (the fourth quarter was incorporated into the final report). These quarterly reports were prepared for inhouse use and were above and beyond the reports required by the funding agency. Apparently the quarterly reports were patterned after a standard format because certain sections in each report were not completed, but the identification of the sections, and indeed, spaces for responses/information were included in all three instances.

The length, form, and information type varied among the three quarterly reports. The length of the total report ranged from nine to eleven pages with an average page length of 9.33. Data were provided in both numerical and narrative form. The data were organized around the two major divisions of: (1) client data, and (2) staff data. These two major divisions contained a total of 16 sections; although, as mentioned above, not all sections were applicable to the Orthopedic Homebound Program.

Following a recommendation from the previous year's evaluation, a Quarterly Report Analysis Form (QRAF) was designed for the third year evaluation. The purpose of the QRAF was to capture the essence of the quarterly report data and present it in an objective, usable manner. Given that some of the data were actual figures (such as number of college credits staff completed) while other information was in narrative form, the design and completion of the QRAF was not a simple task. The eight page final form of the QRAF with the data from the three reports filled in the appropriate places appears as Appendix G.

Table 4 presents a summary of the quarterly report data appearing in Appendix E. Inspection of the data in Table 4 presents an interesting "snapshot" of the average program activities completed during the first three quarters of the third year. For example, in the client category, about eight (8) client evaluations were conducted, about eight (8) cases were managed, and 171 on-site visits to homes were conducted each quarter. Further elaboration of the on-site visits shows most to be conducted by three staff members whose average number of visits per quarter ranged from 29 to 83. Analysis of the narrative comments regarding staff activities yielded a set of five distinct clusters of activity. The average number of entries per cluster for each quarterly report ranged from almost two to just over six. The category of public education, prevention, and presentations reported that the agency's goal of 186.8 person hours per quarter was exceeded by almost 41 person hours per quarter. Category E reveals that the program director devoted 25% of her time to direct services to clients. Last, regarding staff development and staff training, Table 4 shows that the staff exceeded the target goal by over 54 hours per quarter.

Table 4

Summary Data from Three Quarterly Reports

General Category Items in Category	Total Number	Average Number
A. Client Data		
1. Number of intake and other evaluations	23	7.67
2. Number of cases managed	N/A	8.33
3. Number of on-site visits to homes	514	171.33
B. On-site Visit Information Expanded		
1. Staff member #1	86	28.67
2. Staff member #2	250	83.33
3. Staff member #3	111	55.50
4. Other staff members	67	N/A
C. Staff Activity Narrative Comments		
1. Interactions with other agencies/ institutions	13	4.33
2. Services for parents mentioned	14	4.67
3. Staff training/development items	5	1.67
4. Community awareness, public education, etc.	10	3.33
5. All other items, e.g., program continuation, job descriptions, training grant, record keeping, etc.	19	6.33
D. Efforts toward public education, prevention, etc.		
1. Number of staff x quarter person hours	5604	1868.00
2. Program goal (10%) in person hours	560.4	186.80
3. Number of hours devoted to community awareness	682	227.33
E. Direct Services Goal for Professional Trained Supervisory and Support Staff		
1. Percent of program director's time devoted to direct service	N/A	25%
2. Total number of hours of program director's time in direct service	360	120

Table 4 (Continued)

General Category Items in Category	Total Number	Average Number
F. Staff Development		
1. Total center-based inservice hours generated (total staff x number hours each session)	66	22
2. Total number of college credits by all staff	30	10
3. Number of staff development hours over the target goal	163	54.33

In summary, three quarterly reports submitted to the host agency provide an interesting picture of the first three quarters of the project year. Containing both numerical and narrative information somewhat difficult to capture and report easily, they are reflective of the program's varied activities. Data displayed in the full table and in the summary table reveal the program to serve a low number of clients but with a high number of direct client services including home visits. Staff reported they exceeded the agency's targets for: (1) public education activities, (2) direct services to clients, and (3) staff development hours. Finally, a total of 26 major, different staff activities during the three quarters were clustered into five categories.

Parent Newsletters

A monthly newsletter to parents was begun in January, 1979. Titled "Orthopedic Homebound Monthly Newsletter," the purposes were: to establish a communications link with the parents, to provide useful new information to parents, and to reinforce activities and exercises taught by the home trainers. The parent newsletter was a short, simple, and inexpensive method of keeping in touch with parents. It was produced by the OHP staff, copied on an office copier, and mailed to the parents. Two sample monthly newsletters appear in this report as Appendix H.

Evaluation of the monthly parent newsletter required a locally-developed instrument. Utilizing program staff and evaluator input, a draft Newsletter Evaluation Questionnaire (NEQ) was developed in October 1979. This draft version of the NEQ was fieldtested with three program parents that same month. Based on the fieldtest of the instrument, a revised version of the NEQ was designed for the end-of-program evaluation.

A copy of the final version of the Newsletter Evaluation Questionnaire appears in Appendix I. This final version was printed on green stock in order to increase the response rate.

Collection of data via the NEQ required several steps. In mid-June, 1980, a copy of the NEQ; a cover letter; and a stamped, self-addressed envelope was mailed to the eight (8) households named by the program staff. On July 1, 1980, another cover letter; NEQ; and another stamped, self-addressed envelope was mailed to each non-responding household. Finally, in mid-July, 1980, a research assistant at AEL telephoned each of the non-respondents and interviewed one parent using the same evaluation questions contained in the NEQ. Through the combination of mailing and telephone procedures, all eight (8) households responded to all the evaluation items on the NEQ.

Results of the parents' responses to the NEQ items are presented in narrative and table form. The average number of years their children had been in the OHP (question #1) was a little over one and half years with a range of one and half to three years. Four parents reported they received between five and sixteen monthly newsletters (question #2). The average number of newsletters received by parents was four while three parents didn't know how many newsletters they received. In response to the question (#3) asking if they liked the newsletter, three parents responded "Yes, very much," four responded "Yes," and one said "OK". Question number nine asked parents to rate the overall quality of the newsletters. To this question two parents rated the newsletters "Excellent," five rated them "Good," while just one parent rated them "OK".

Table 5 presents the evaluation items and parents' responses to six other NEQ questions. Sixty-three percent of the parents said they saved

Table 5

Parents' Responses to Selected Newsletter Evaluation Items

Evaluation Item	Yes No. (%)	No No. (%)
4. Do you save your monthly Newsletters?	5 (63)	3 (37)
5. Did you read the whole Newsletter each time it came?	7 (88)	1 (12)
6. Have you found useful information in the Newsletter?	7 (88)	1 (12)
7. Is the Newsletter content too technical for you?	2 (25)	6 (75)
8. Have you performed any of the Newsletter activities with your child?	7 (88)	1 (12)
10. Have you ever written to or telephoned any of the organizations, agencies, or persons listed in the Newsletters?	3 (37)	5 (63)

their monthly newsletters, 88% of the parents reported they read the whole newsletter each time it came, 88% said they found useful information in the newsletter, and 75% reported the content not too technical. Regarding the item asking if the parents had performed any of the newsletter-suggested activities with their child, 88% reported that they did. Thirty-seven percent of the parents said they wrote or telephoned one or more of the organizations, agencies, or persons listed in the newsletters.

NEQ item number eleven provided room for respondents' open comments and/or concerns. A total of three respondents provided comments and/or concerns. All three comments were judged by the evaluator to be positive in nature. One parent wrote "I enjoy the information," a second wrote "Those people at Shawnee Hills school put forth a lot [of] effort to learn the children and they are nice." The third parent said she enjoyed the examples of ways to protect children during play and other exertion.

In summary, the program's "Orthopedic Homebound Monthly Newsletter" seemed to be a very successful activity. Parents rated it high in quality, they liked it, most read the whole issue and found useful information in it, and the majority of the parents saved the newsletters. More importantly, all but one parent reported that they performed suggested activities in the newsletter with their child, and another parent gave an example of this type of activity as a positive response in the open comments section of the questionnaire. Seventy-five percent of the parents did not find the content too technical and three parents had contacted an organization, agency, or person named in one of the newsletters.

Parent Handbook

Based on requests from several sources, including program parents, a handbook for parents of severely impaired/mentally retarded children and youth was written. The parent's handbook was designed to be a resource book for present and future activities, agencies, and services available to parents of severely impaired/mentally retarded children and youth. The first version of the parent's handbook was a draft which was to be revised based on data collected by the evaluation.

Evaluation of the draft copy of the parent's handbook necessitated a locally-developed instrument. A draft version of the Parent Handbook Evaluation Questionnaire (PHEQ) was developed by the evaluator and checked for content by the program director. This draft version was pilot tested in May, 1980. Based on the pilot test, it was revised slightly. The final version was a eight-item, single page device: most questions were open-ended. A copy of the final version of the PHEQ appears in Appendix J. This final version was printed on pink stock to assist in increasing the response rate.

Collection of data via the PHEQ was rather straight forward. A list of educators especially interested in the program was maintained throughout the evaluation. Persons sending inquiry letters, personal contacts, and attendees at conference presentations were the main sources used to compile the mailing list. In June and July, 1980, a draft copy of the parent handbook; a cover letter; an evaluation form; and a stamped, self-addressed envelope was mailed to fifteen special educators. Due to the copying and mailing expenses, no repeat mailings were conducted. By mid-August, 1980, ten of the fifteen PHEQ forms were received by the evaluator for a 67% response rate.

Results of the administration of the PHEQ appear in this and the following paragraphs in narrative form. A variety of job roles were represented by completers of the PHEQ. Four of the ten respondents were teachers. The other six respondents represented each of the following job titles: family service coordinator, home training consultant, state education agency consultant, curriculum specialist, and a college student (senior). In terms of the number of years of teaching experience respondents had, they reported a range of zero to twenty-eight years, for a mean 8.6 years and a standard deviation of 8.8 years.

Question number three on the PHEQ asked respondents to indicate their overall rating of the parent handbook on a scale from 1 (low value) to 9 (high value). With all persons responding, the mean rating was 6.8, the standard deviation was 1.99, and the range was from 3 to 9. Thus, respondents' overall rating of the parent handbook was between average and high level.

The fourth question on the PHEQ asked which materials or sections did respondents find most helpful or useful. All ten respondents answered this questionnaire item. Four respondents named the section "How Children Learn" as their sole response while three others named it as one of several sections being most helpful or most useful. Two respondents named the section titled "Organizations and Agencies" as their sole response while four others named it as one of several sections. All of the remaining responses were part of multiple responses by those answering the fourth question. The section titled "Training Hints" was named by three respondents. Three respondents also answered this item with the section titled "Your Child's Future". Receiving one mention each were the sections titled "A Child Learns Through Activities" and "Glossary for Terms Used".

Item number five on the PHEQ asked respondents to name which materials or sections of the parent handbook they found least helpful or useful. All ten respondents answered this questionnaire item although one respondent found it impossible to name any section as least helpful. Four respondents named "How Children Learn" as the least useful or helpful (two as sole response, two as half of a two item response). The section "Terms Used in Training" was named by two respondents as least useful or helpful. No other specific section was named more than once by respondents. Named once by respondents to question number five were: "Discipline, Conclusions, Training Hints, and A Child Learns by Recognizing Cause and Effect".

The sixth question on the PHEQ asked what areas should be added or expanded. All ten respondents answered this questionnaire item although one response was not specific enough to code in the data analysis. Two respondents answered the sixth question with the section "How Children Learn" as their sole answer and one other respondent mentioned it as part of a multiple answer. Two respondents named "Play Activities" as the area they think should be expanded or added (one as a sole mention, one as part of a multiple answer). The section on "Discipline" was named three times (once as a sole response and twice as part of a multiple response). One response each was given for the following sections or proposed sections. One person stated that the section on manual communications should be expanded, the same respondent felt that perhaps a section on the medical evaluation for hyperactivity should include material for middle and secondary-age learners because their interests and motivation differ from the primary-age learner.

Question number seven revolved around the organization or format of the parent handbook draft and asked for suggestions for improvement. All ten respondents answered this question. The responses were classified into the broad categories of Positive, Neutral, or Negative. Five respondents provided information in answering the seventh question which was coded as Positive. Specific portions of their responses included the following quotes: "...well organized," "...very good," "...really good," and "the organization and format are good." Three responses were coded as Neutral chiefly because they contained suggestions for improvement but made neither a positive nor a negative remark in addressing their replies. Two responses were coded as being Negative because of the wording of their reply. Specifically, one respondent wrote "Weakest point in [the] handbook," while the second negative response was "The format is undeveloped".

Question number eight was the last question on the PHEQ. It asked for other comments, thoughts, or suggestions for improving the handbook. Nine of the ten respondents provided information in the space provided. The responses varied considerably in both form and focus. Two of the responses related to the graphics of the final version. Both these respondents suggested that each section be made to stand our more clearly by either (a) starting each section on a new page, or (b) by using some "distinguishing graphic effect". One respondent felt it would be accepted well by parents because it is "brief and to the point" and "encouraging, instead of discouraging parents". Another respondent took this opportunity to mention how much he or she liked the listing of local agencies and organizations at the end of the handbook. Another respondent wrote: "You've done a beautiful job. Could you, would you, please help us secondary people!". One respondent replied that the sections might be divided

into subsections which address the specific target child's handicapping condition while another person wrote that more examples of activities should be provided.

In summarizing the evaluation of the draft version of the parent handbook, data collected from ten respondents were generally positive. The overall rating of the parent handbook was between average and high value. The section titled "How Children Learn" was ranked the most helpful by seven of the ten respondents while the "Organizations and Agencies" section was ranked similarly by six respondents. Four other sections received a total of eight mentions (this was a multiple response option item). When asked to name the least helpful or least useful section, respondents had a more difficult time doing so--and there was much less agreement across the sections. Specific suggestions for which sections should be expanded and/or added were provided by nine respondents. Regarding the organization or format of the handbook, five positive, three neutral, and two negative responses were coded from the responses given by respondents. Generally, all the responses were well thought out and provide very useful data to program managers and/or others planning to revise the draft copy of the parent handbook.

Conference Presentations

Since the OHP was in its third and final funding year, increased attention was focused on disseminating the model and its implementation. A part of the third year's workplan was devoted to developing a slide-tape presentation about the OHP and delivering it at local, regional, state, and national conferences and/or meetings. Preparation for this segment of the workplan had begun even earlier due to the need for a set of slides

to draw upon and the necessity of submitting national conference program proposals well in advance of the scheduled conferences.

Meetings with the OHP staff during the formative stages of the development of the slide-tape presentation and the overall plan for the OHP presentations aided in developing the Presentation Evaluation Form (PEF). The PEF was developed as the OHP presentations took shape and form. Program staff were able to assess the instrument's content validity during these early development stages. The PEF was designed during the Fall of 1979 since it was needed for several winter and early spring, 1980 conferences. In its final form the PEF contains eight different questions. A copy of the final version of the Presentation Evaluation Form appears in Appendix K. The PEF was printed on white stock to make it distinguishable from the other evaluation forms.

Data collection via the PEF was conducted at four formal sessions at conferences. Three of these sessions were at national conferences of professional associations concerned with special needs learners while the fourth was a regional meeting within the state of West Virginia. More specifically, the PEF was administered and collected at the conclusion of the OHP presentation at the following national conferences: (a) American Association of Mental Deficiency, (b) American Association of Education for the Severely/Profoundly Handicapped, and (c) Council for Exceptional Children. The number of participants for each of the four presentations varied from five to twenty-one. Because the OHP presentation was designed to be the same at all four sites, and because the same PEF was utilized at all four sites, the data were aggregated for evaluation purposes. However, it should be recognized that several PEF respones, e.g., small group

interaction and informality, were germane to one or more presentations, but not all four.

A total of 42 completed PEFs were returned by conference participants. Of these 42 respondents, the following job functions were represented more than once: administrator (N = 7), teacher (7), teacher aides (6), college student (6), and services, e.g., therapist (4). The following job functions were represented once each: home training consultant, RN and parent trainer, consultant, state supervisor/advocate, education specialist, evaluator, teaching assistant, home trainer, parent trainer, and one person responded by naming several job functions. Thus a wide variety of job functions were represented at the OHP presentations.

Table 6 presents the results of data collected in Part II and Part III-A of the PEF. The four component evaluations and the overall evaluation were all relatively high. Each item received a rating above 3.5 on the 5 point scale. The "Overall evaluation of the presentation" (4.14), the "Development of the Orthopedic Homebound Program" (4.11), and the "Description of the OHP services" (3.97) were the highest rated presentation components. The "Evaluation of the OHP" (3.58) was the lowest rated presentation (although still a relatively high rating) and it also had the largest standard deviation value.

In Part I-B of the PEF participants were asked to name one strength of the OHP presentation. All but two participants responded to this item. They provided a variety of responses to the charge of naming a single strength of the OHP presentation. The evaluator read and assigned the responses to categories based on a judgement of their contents. Table 7 presents the results of this categorization process. Seven different categories of responses emerged from the respondents' write-in answers.

Table 6

Participants' Ratings of the Presentation Components

Topic	Number[a]	Mean	Standard Deviation
Development of the Orthopedic Homebound Program (OHP)	36	4.11[b]	0.62
Orthopedic Homebound model	37	3.89	0.66
Description of OHP services	36	3.97	0.84
Evaluation of the OHP	36	3.58	1.05
Overall evaluation of the presentation	42	4.14	0.75

[a]Number varies because several respondents chose not to respond to several items.

[b]The response range was from 5 (Highly Effective) to 1 (Ineffective).

Table 7

Participants' Categorized Responses to the Question of Naming One Strength of the OHP Presentation

Category Name(s)	Number of Entries[a]	Rank
Slide-tape presentation, slides, visuals	14	1
Comprehensiveness, thoroughness, depth	7	2
Discussion, question and answer portion	6	3
Background of OHP, social context, input factors	5	4
Organization and/or delivery of presentation	3	5[b]
Humanistic program, humanly-focused	3	5[b]
Informality and/or openess of presenters	2	7

[a]There were two blanks out of forty-two instruments.

[b]Tie.

Clearly, the slide-tape presentation and/or slides was the most frequently mentioned item with twice as many nominations as the next category. The second, third, and fourth most mentioned categories were, respectively: (a) comprehensiveness, thoroughness, depth; (b) discussion, question and answer portion; and (c) background of OHP, social context, and input factors. Three other categories were mentioned less often as the strength of the presentation.

Item III-B on the PEF asked respondents for reactions or comments which are important in assessing the value and content of the OHP presentation. Of the 42 completed PEFs, there were 27 responses to this open comment/reaction item. These 27 responses varied widely in terms of topics and specificity. In order to present an analysis of these items, the evaluator assessed each statement to discern the general tone of the response. Comments and/or reactions were coded as being primarily Positive, primarily Negative, or Neutral. Neutral comments were those which contained both Positive and Negative statements or were noncommittal as being more positive or negative than not. Of the 27 comments and/or reaction statements made by the participants in the conferences, ten or 37% were judged to be Positive, seven or 26% were judged to be neutral, and the remaining ten or 37% were labelled Negative.

To sum, the OHP presentations made at one regional and three national conferences were received well by session participants. All presentation components and the overall presentation ratings were rather high and also consistent. Asked to name one strength of the OHP presentation, 40 out of 42 respondents did so, and they named a variety of items indicating that the presentations had numerous strengths. The slide-tape presentation was, however, the clear cut choice as the major strength of the

presentations. In the open comments/reactions section, equal numbers of Positive and Negative comments were made while a little more than one fourth of the comments were judged to be Neutral.

Culminating Seminar.

As the OHP concluded its final funded year and with many of the original goals met during the course of the program's three years of operation, the program director conceived the idea of a concluding seminar. The purpose of the seminar was to bring together parents and professionals interested in services for the severely handicapped to discuss processes and products and to introduce topics of lasting concern of all once the project concludes. In a way, the OHP seminar was a capstone event for much of what had already been done in the four county service area, but it also introduced relevant topics for parents and professionals to consider such as parents as advocates and estate/trust planning.

The OHP-sponsored event was titled "Serving the Handicapped: A Seminar for Parents and Professionals". Scheduled for a day and one half in duration, it was held at the West Virginia University Medical Education Building in Charleston, West Virginia. The program consisted of three general sessions, three workshops, and two forums. Three nationally-known consultants were contracted to make the general session presentations. Other seminar events were lead by local professionals in West Virginia. A reduced copy of the announcement flyer and a copy of the detailed agenda both appear in Appendix L.

Evaluation of the seminar was conducted via the administration of the locally-developed Seminar Evaluation Form (SEF). The SEF was designed by the evaluator following the determination of the final agenda. Because

seminar planners knew early on that not all participants would be able to attent all seminar sessions (and indeed they had numerous registration arrangements to facilitate partial attendance), one important criterion in the development of the SEF was that it allow participants to identify and evaluate just those sessions they attended. Another important instrument development criterion was simplicity of administration and completion. A draft copy of the SEF was shared with the OHP program director and seminar organizer to assess content validity. This done, the SEF was printed on yellow stock to facilitate data collection. A copy of the final form of the SEF appears in this report as Appendix M.

Invitations to the seminar were distributed widely in West Virginia. Also, some seminar flyers were distributed to neighboring states. Basically, these invitations went to individuals and/or organizations who had shown an interest in services for handicapped persons. Typical organizations included parent support groups, councils for retarded citizens, professional educator associations, professional medical societies, and similar groups. Those organizations unable to send representations to the seminar were encouraged to send catalogs and flyers displaying resource materials of interest to persons dealing with severely handicapped individuals either as a parent or as a professional. These items were set up on display tables convenient to the seminar participants. It was observed by the evaluator that a total of 47 different pieces of resource material were on display and available to participants. Most of these items were available in quantity for participants.

Seminar evaluation via the SEF was conducted by the evaluator. Forty-six individuals registered for the seminar. Thirty-four of these registrants completed and returned the SEF for a completion rate of 74%.

Seminar participants represented every job function title on the SEF save nurse. Job categories with more than one representative included: teacher (N = 8), services, e.g., therapist (7), supervisor (4), parent (3), and social worker (3). In the "Other" job category the following titles were supplied by participants: educational researcher, mental health technician, administrator, teacher aide, home trainer, engineer, trainer, occupational therapist, and economic service worker.

Seminar participants' attendance and evaluations of the seminar sessions are presented in Table 8. Recall that not all participants attended all sessions. For example, some parents could attend only the evening session whereas others could attend only the daytime sessions. Table 8 shows that first day sessions were attended more heavily by SEF completers than the second day functions. Seminar participants rated all sessions but one relatively high. On the five point rating scale, all sessions received a mean rating above 3.5 except for media (film) workshop. It should be noted that this session had the fewest attendees and also attained the largest ratings' standard deviation. The highest rated session was the third general session--clearly. This session received a mean rating of 4.50 on the five point scale. The overall seminar rating was a rather high mean score of 3.88 with a standard deviation value of 0.96.

A summary of the evaluation of the OHP-conducted seminar shows it to be a success. A total of 46 persons registered for the event, 34 completed evaluation forms, and all but one session received relatively high ratings on a simple five point scale. One particular session received a very high rating from participants and, interesting enough, it was the last seminar session. The overall rating of the whole seminar from 33

Table 8

Participants' Attendance and Evaluation of Seminar Sessions

Seminar Session Title	Number of Respondents Attending	Percentage of Respondents Attending	$\bar{X}$	Standard Deviation
General Session I: Self-Help Skills for the Severely Handicapped	29	85.3	3.52	1.12
Workshop 1: Neuro-development Techniques	27[a]	79.4	3.65	0.98
Workshop 2: Communication for the Severely Handicapped	21	61.8	3.71	0.85
Workshop 3: Media (films)	7	20.6	2.71	1.50
General Session II: Living with a Handicapped Child and Still Having Life	16	47.1	3.56	1.21
Forum No. 1: Legal Issues, Future Planning, and Guardianship	19	55.8	3.58	1.21
Forum No. 2: Medical and Financial Issues	14	41.2	3.64	1.00
General Session III: Parent Groups: What They Can Do	14	41.2	4.50	1.09
Overall Seminar Rating	33[a]	97.1	3.88	0.96

[a]One respondent each chose not to respond to these items.

participants was relatively high. Thus, in all aspects reported here, the OHP culminating seminar was a success.

REFERENCES

Cone, John D. The West Virginia System. Morgantown: West Virginia University, circa 1979.

Sailor, Wayne and Mix, Bonnie Jean. TARC Assessment Inventory for Severely Handicapped Children. Monterey, CA: McGraw Hill, 1975.

APPENDICES

Appendix A:

Occupational Therapy Evaluation Form

SHAWNEE HILLS MR/MH CENTER
OCCUPATIONAL THERAPY EVALUATION

I. Name:_____ DOB:_____ Age:_____

Program:_____ C.P.C._____

Date:_____ Staffing Date:_____

Initial Eval.:_____ Re-eval.:_____ Date of last Eval.:_____

Diagnosis:_____

_____

II. Past History:_____

_____

_____

III. Observations:

1. Muscle Tone: Normal_____ Hypertonic_____ Hypotonic_____ Athetoid_____

2. Range of Motion Limitations:

U/E_____

_____

L/E_____

_____

3. Reflexes:

Moro_____ ATNR_____ STNR_____ Hand Grasp Reflex_____ Extensor Thrust_____

Protective Extension
a. Forward_____
Sideways R_____ L_____
Backward_____

Tonic Labyrinthine
a. Supine_____
b. Prone_____

4. Sensory:_____

_____

_____

5. Other Physical Abnormalities:_____

_____

_____

IV. Skill Areas:

1. Gross Motor Skills: _____

2. Fine Motor Skills: _____

3. Feeding Skills: _____

4. Self Help Skills: _____

V. Recommendations: _____

_____
Occupational Therapist

_____
Date

Appendix B:

Sample Individual Program Plans, Activities, and Universal Data Sheet

INDIVIDUAL PROGRAM PLAN DATE August 1979 to July 19[illegible]

Name _____ Client # _____

D.O.B. 5-2-75 Legal Competency Status _____

Program Orthopedic Homebound Entry Date February 1979 CPC Cindi Deese

Annual

Staffing Date _____ Additional Staffings _____ date _____ date _____ Cat

Assessments	Instrument	Completed by	Date	Update
Physical	Child History Form	Dr. Graham	11-24-78	
Dental				
Psychological				
Educational				
Developmental	WVAATS	Cindi Deese	7-23-79	
Speech/Language				
Audiological				
Social History	Yes	Brenda Newell	1-19-79	
Visual				
Nutritional	Assessment	Cindi Deese	7-5-79	
Vocational				

I agree to this Individual Program Plan and will cooperate in meeting goals as outlined. I understand that this plan will be reviewed in 6 months and/or at the request of any Team Member.

SIGNATURE/TITLE TEAM MEMBER /Parent	DATE	UPDATE
Cindi Deese CPC	8-1-79	
Robin Millstone HT	8-1-79	
David McBride OTR	8-1-79	
Linda Lewis RN	8-1-79	
Earl L. Hunt MD	8-14-79	
[illegible] Speech/Lang Pathologist	8-14-79	

Date August 1979 to July 1980

INDIVIDUAL TREATMENT/TRAINING PLAN

Name _____ Client No. _____

Case Manager Cindi Deese Program Orthopedic Homebound

umber	Annual Goal	Schedule/Strategy	Person Responsible	Target Date	Date Obtaine
1.	will turn head or eyes toward source using sensory stimulation (visual, tactile, auditory)	Home Visit on Thursday	Mr. and Mrs. , Parents - Robin Millstone, Home Trainer	7-80	
2.	will maintain head lift in midline for 15 seconds while lying prone over roll.	" "		7-80	
3.	will follow an object from right to left within 6" of his face.	" "		7-80	
4.	will respond to his name when spoken by locating sound with eyes.	" "		7-80	
5.	will follow one part commands.	" "		7-80	

NAME _____ DATE July 1979

SKILL AREA Cognitive PRIORITY NUMBER 3

ANNUAL GOAL will follow an object from right to left within 6" of his face.

Short Term Instructional Objectives	Criteria	Person Responsible (Name & Title)	Starting Date	Review Date	End Dat
1. will follow an object from left to midline within 6" of his face.	Two tries 2 consecutive days	Robin Millstone (H.T.)	8-79		
2. will follow an object from left to right within 6" of his face.	same	Mr & Mrs (parents)	10-79		
3. will follow an object from right to left within 6" of his face.	same		12-79		

THE WEST VIRGINIA SYSTEM

Method Card

SKILL AREA: Gross Motor	SUB-AREA: Controls Head	OBJECTIVE NO. Head - 1	0-2 Months

OBJECTIVE Given the student placed on stomach by the trainer and an indication to turn head to left/right (i.e., toy dangled to left/right), student turns head to the left/right within 5 seconds.

MASTERY CRITERION:

3 consecutive correct responses on each side

METHOD

1. Place student on a mat on his/her stomach. Speak to the student or dangle a noisy, colorful toy to the left. If CORRECT (i.e., student turns head to left), reinforce and continue until mastery criterion is met. If NO RESPONSE, repeat Step 1. If STILL NO RESPONSE or INCORRECT, go to Step 2.

2. Repeat Step 1, adding a physical prompt: slowly raise the student's shoulder on the side to which you want him/her to turn. If CORRECT, reinforce and slowly withdraw your assistance until the student turns his/her head with you only touching his/her shoulder. Then return to Step 1. If NO RESPONSE or INCORRECT, go to Step 3.

3. Repeat Step 1, adding a physical prompt: stroke the student's cheek near the corner of the mouth on the side to which you want him/her to turn. If CORRECT, reinforce and slowly withdraw your assistance until the student turns his/her head with you only touching his/her cheek. Then return to Step 1. If NO RESPONSE or INCORRECT, go to Step 4.

4. Repeat Step 1, adding a physical prompt: move the student slowly, assisting him/her in turning his/her head. If CORRECT, reinforce and slowly withdraw your assistance until the student turns his/her head with you only touching the side of the head. Then return to Step 1. If NO RESPONSE or INCORRECT, go to step 5.

5. If repeatedly INCORRECT, write a sub-objective or see a physical therapist for additional suggestions.

PREREQUISITES

Ambulation	O	O	Sign Language
Vision	O	O	Use of Hands
or			
Hearing	O	O	
Speech	O	O	

STUDENT GROUPING

No Supervision	Sm. Group (2-4)
Min. Supervision	Lg. Group (5-)
One Student**	

MATERIALS & EQUIPMENT

Mat
Noisy, colorful toy (or favorite food or voice)

SOURCE:

B. Burkart, RPT
3/78

NAME _____ DATE July 1979

SKILL AREA Sensorimotor PRIORITY NUMBER 1

ANNUAL GOAL will turn head or eyes toward source using sensory stimulation (visual, tactile, auditory)

Short Term Instructional Objectives	Criteria	Person Responsible (Name & Title)	Starting Date	Review Date	End Dat
1. Using visual, tactile, auditory stimulation, will turns eyes toward sound within 10 seconds.	Two tries 2 consecutive days	Robin Millstone H T Mr. Mrs parents	8-79		
2. Using visual, tactile, auditory stimulation will turn head toward sound within 15 seconds (stimulation on left)	same		10-79		
3. Using visual, tactile, auditory stimulation will turn head toward sound within 15 seconds (stimulation on right)	same		12-79		

NAME _____ DATE July 1979

SKILL AREA Sensorimotor OBJECTIVE Using visual, tactile, auditory stimulation will turn eyes toward sound within 10 seconds

Mastery Criterion 2 tries 2 consecutive days	**Mastery Criterion**
Method 1. Trainer will present stimulous (toy) 2. will turn eyes toward sound. If no response give verbal prompt, "look here" 3. If still no response use physical prompt. 4. Decrease verbal & physical promps & return to 1	**Method**
Materials/Equipment stimuloos (toys, music box)	**Materials/Equipment**
Schedule 70 Thursday	**Schedule**

PROGRAM IMPLEMENTATION PLAN

NAME _____ DATE July 1979

SKILL AREA Affective PRIORITY NUMBER 4

ANNUAL GOAL will Respond to his name when spoken by locating sound with eyes.

Short Term Instructional Objectives	Criteria	Person Responsible (Name & Title)	Starting Date	Review Date	End Dat
will Respond to his name when spoken on left side by locating sound with eyes within 5 seconds.	2 trics 2 consecutive days	Robin Millstone H. T.	8-79		
will Respond to his name when spoken on right side by locating sound with eyes within 5 seconds.	same	Mr. & Mrs. Harper (parents)	10-79		
will Respond to his name when spoken behind him by locating sound with eyes within 5 seconds.	same		12-79		

THE WEST VIRGINIA SYSTEM

Method Card

SKILL AREA: Receptive Language	SUB-AREA: Responds to Name	OBJECTIVE NO. Name - 1	

OBJECTIVE Given a direction like: "(student's name)", the student independently turns head toward teacher and independently holds in position for two seconds.

MASTERY CRITERION: 4 out of 5 correct responses in 3 consecutive sessions.

METHOD	If CORRECT	If NO RESPONSE	If INCORRECT
1. Sit facing the student and say something like: "___."	Verbally and physically praise the student by saying something like: "Good looking.", while touching the student. Repeat the direction until mastery criterion is reached, then go on to the next objective.	Repeat the original direction. If CORRECT, praise the student and return to the beginning of Step 1. If STILL NO RESPONSE, go to Step 2.	Go to Step 2.
2. Say something like: "___, look." Hold an edible in front of the student's face and gradually move the edible in front of your face, holding it there for two seconds.	Verbally and physically praise the student as he/she turns head toward the teacher. Reward with the edible. Return to Step 1.	Repeat the direction. If CORRECT, praise the student and return to Step 1.	Go to Step 3.
3. Say something like: "___". Grasp the student's chin, turn it toward you, hold it in position for two seconds (or until the	Reward each time less assistance is required. When criterion is met using only a touch cue, return to	Go to a previous objective or write a new sub-objective.	Try the method of a previous objective, write a new sub-objective, or consult the Score

PREREQUISITES

Ambulation	O	O Sign Language
Vision	O	O Use of Hands
Hearing	O	O
Speech	O	O

STUDENT GROUPING

- No Supervision
- Min. Supervision
- One Student**
- *Sm. Group (2-4)
- Lg. Group (≥ 5)

MATERIALS & EQUIPMENT

Edible reinforcers (e.g., cereal, potato chips, pretzels, etc)

SOURCE:

A. Esposito
2/78

student stops any resistance, then hold head in position two seconds. Continue with the prompting procedure gradually reducing the amount of physical assistance needed to have the student perform the action.

If CORRECT

If NO RESPONSE

If INCORRECT

Sequence and Correspon... Chart for additional teaching sources.

PROGRAM IMPLEMENTATION PLAN

NAME _____ DATE July 1979

SKILL AREA Gross Motor PRIORITY NUMBER 2

ANNUAL GOAL will maintain head lift in midline for 15 seconds while lying prone over roll.

Short Term Instructional Objectives	Criteria	Person Responsible (Name & Title)	Starting Date	Review Date	End Dat
will maintain head lift in midline for 5 seconds while lying prone over roll.	Once a day 3 consecutive days	Robin Millstone H T Mr. + Mrs. Parent	8.79		
2. will maintain headlift in midline for 10 seconds while lying prone OVER roll.	Same		11-79		
3. will maintain headlift in midline for 15 seconds while lying prone over roll.	Same		4-79		

THE WEST VIRGINIA SYSTEM
Method Card

SKILL AREA: Gross Motor	SUB-AREA: Controls Head	OBJECTIVE NO. Head - 2	0-2 Months

OBJECTIVE Given the student held in an upright position in the trainer's arms so that his/her head is well above the trainer's shoulder*, the student keeps his/her head steady for 5, 10, 25 seconds.

MASTERY CRITERION: 3 consecutive correct responses

METHOD

1. Place student upright in your arms so that his/her head is well above your shoulder. If CORRECT (i.e., student keeps head steady for 5 seconds), reinforce and continue until mastery criterian is met. Then repeat for 10 and 25 seconds. If NO RESPONSE or INCORRECT, go to Step 2.

2. Seat student on your lap, but not resting against your body, allowing him/her to try to hold his/her head steady. Support trunk by holding around chest. If CORRECT, (i.e., student keeps head steady), reinforce and continue until mastery criterion is met. If NO RESPONSE or INCORRECT, go to Step 3.

3. Repeat Steps 1 or 2, adding a prompt: have a second person stand facing student with a rattle, bell, etc. to encourage him/her to raise head. If CORRECT, reinforce and continue with Step 1 and 2. If INCORRECT, to to Step 4.

4. Repeat Step 3, adding physical prompt: have the person facing student gently support student's chin as s/he continues to ring the bell or shake the rattle. Reinforce as soon as head is held steady and has been held there for 3 seconds. Then:
   a. Repeat Step 4, using less force in your physical prompt than on previous trial.
   b. Continue with Step 4a until student lifts head with just a touch to his/her chin. Reinforce each time the student required less assistance.
   c. If CORRECT, return to Steps 1 and 2.
   d. If INCORRECT, go to Step 5.

5. Hold student upright in your arms so that his/her head is resting against your shoulder. Support him/her with one arm under his/her seat and one

PREREQUISITES

Ambulation	O	O Sign Language
Vision	X or O	O Use of Hands
Hearing	X or O	O
Speech	O	O

STUDENT GROUPING

- No Supervision
- Min. Supervision
- One Student**
- Sm. Group (2-4)
- Lg. Group (≥ 5)

MATERIALS & EQUIPMENT

Adult chair
Noisy, colorful toy (e.g., bell, rattle, mirror), or favorite food or voice.

SOURCE:

B. Burkart, RPT
3/78

hand on his/her back. If CORRECT (i.e., student holds head perpendicular to trainer's shoulder), reinforce and return to Step 1. If INCORRECT, use prompts as described in Steps 3 and 4.

6. If student is repeatedly INCORRECT, see a physical therapist for additional suggestions.

---

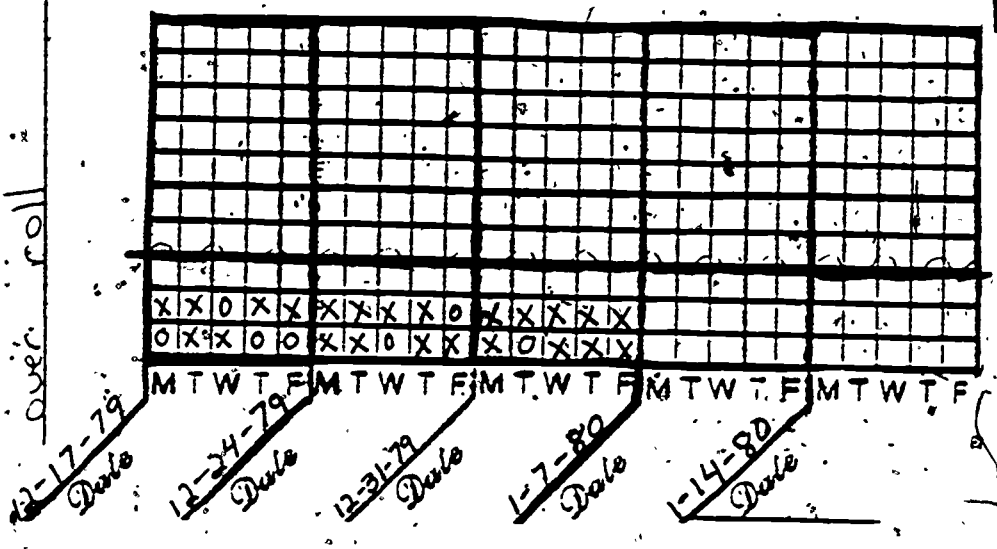
* CAUTION: If the student tends to become very stiff (throws head back and arches his/her back), try holding him/her in a flexed position (knees bent to chest and arms crossed over chest).

The West Virginia System
Universal Data Sheet

Student
Program: Ortho-Home
Location: Home
Trainer: Robin Millstone

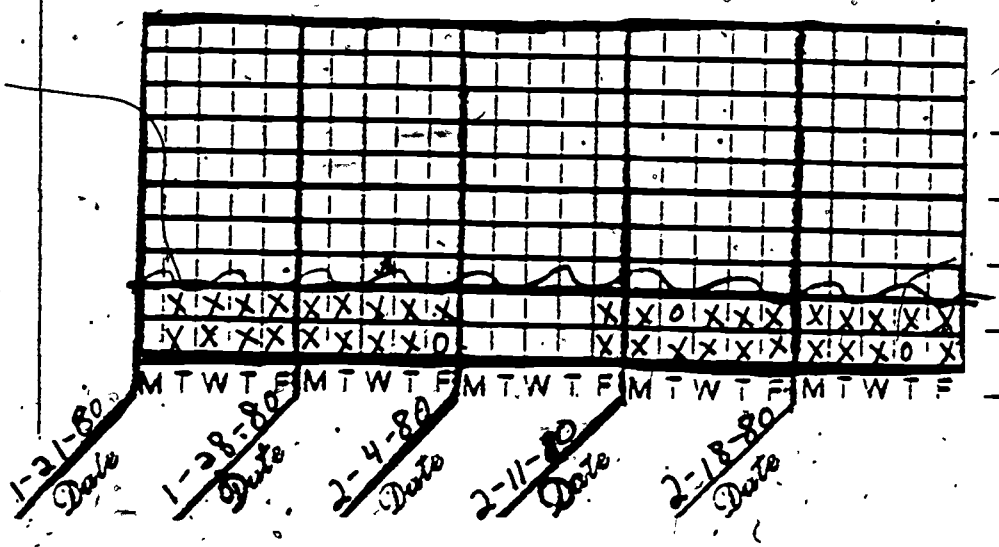
CODE

will maintain head
lift in midline for 5 sec
while lying prone
over roll



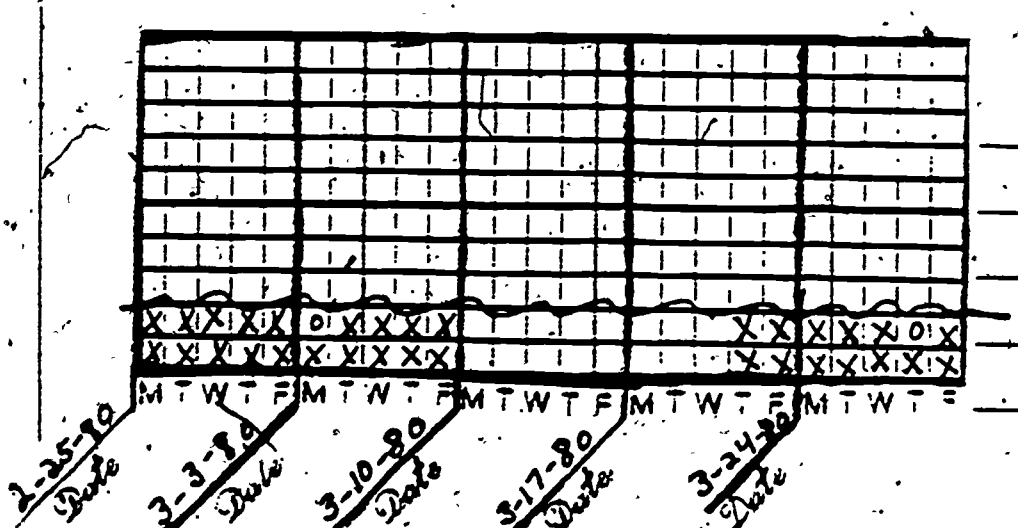
Comment

Step 1



Comment

Step 2

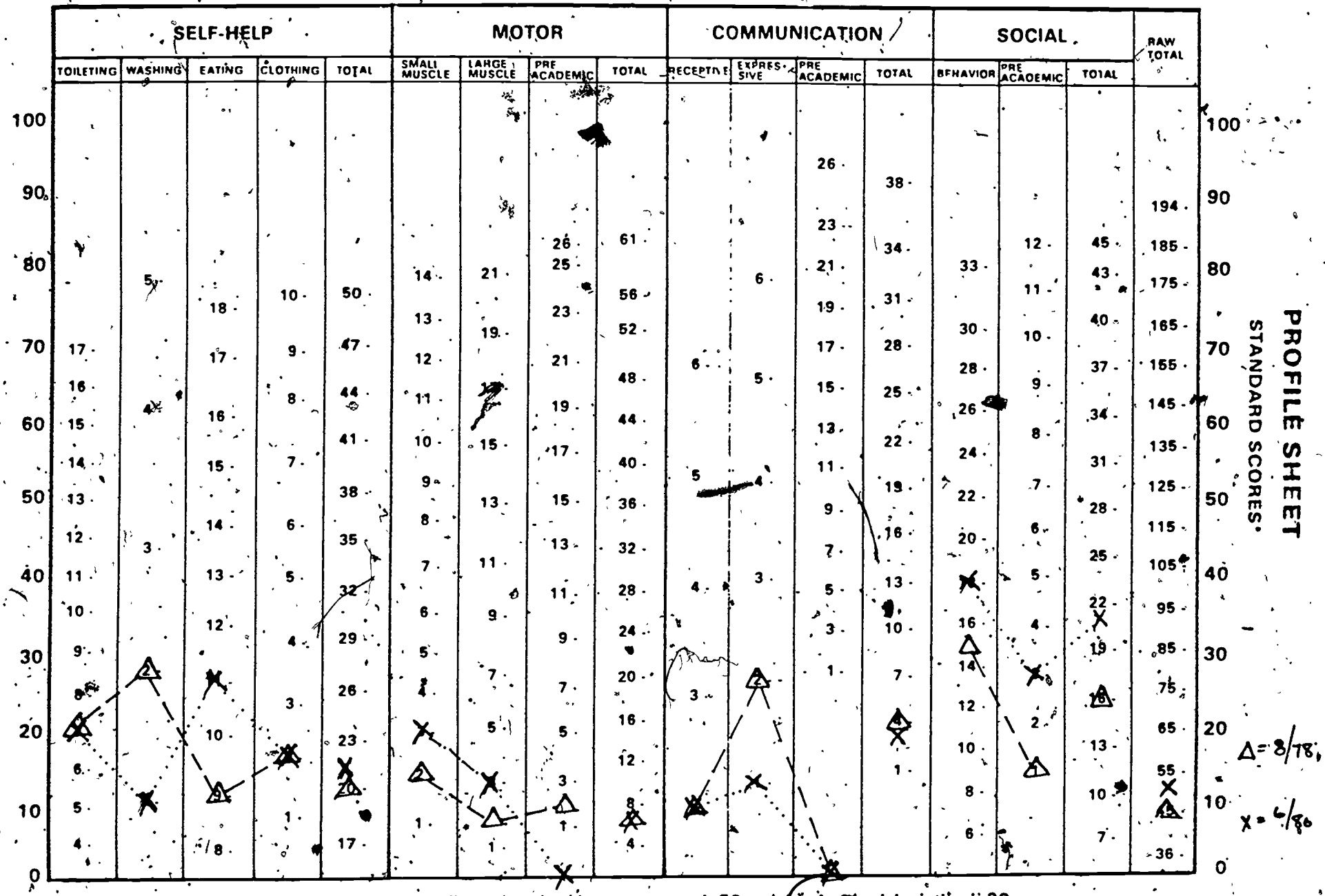


Comment

Appendix C:

TARC Profiles

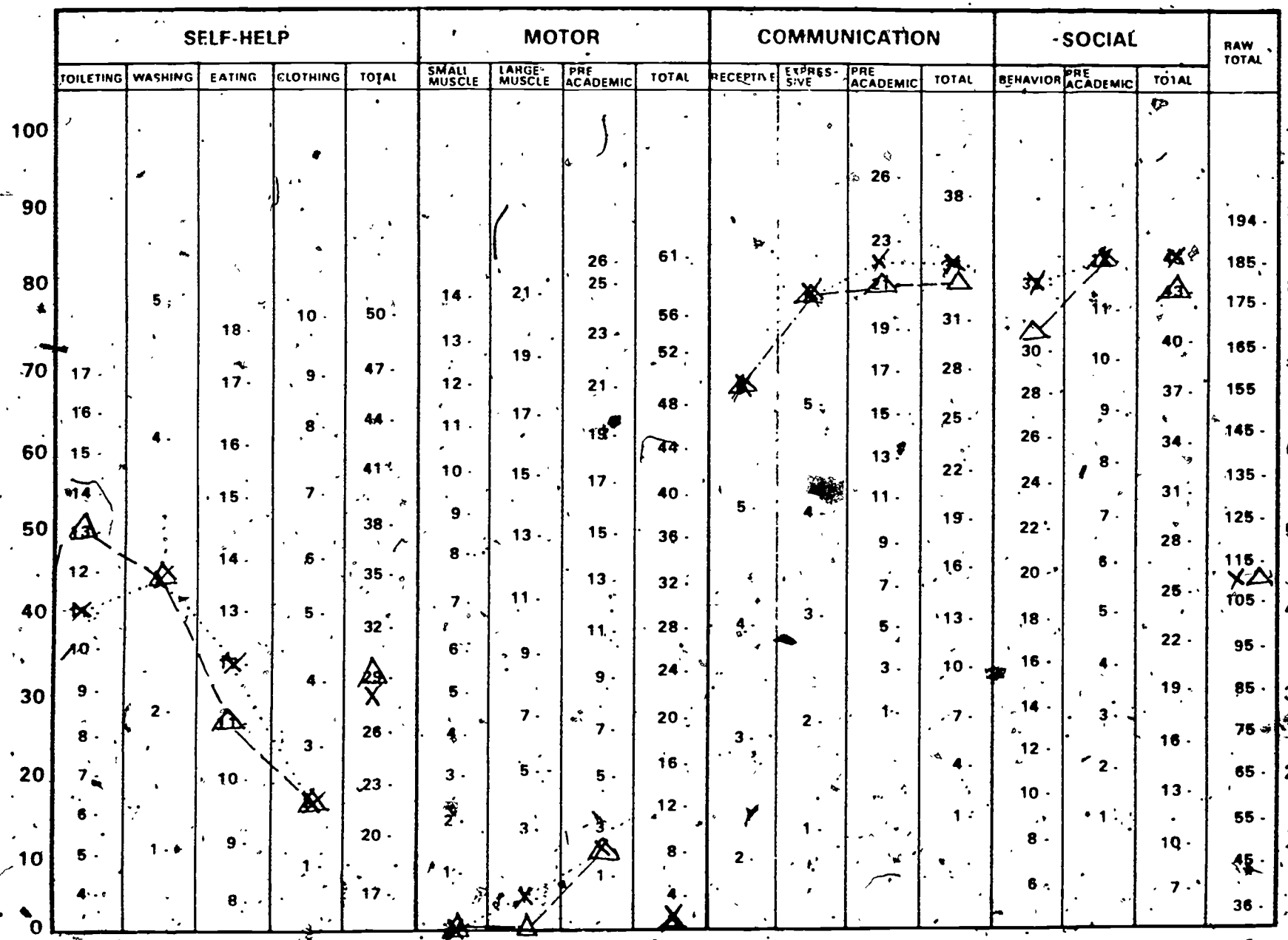
NAME #105 CLASS OR UNIT _____ RATED BY _____ DATE _____
(or identification number)



*Standard scores here are adjusted so that the mean score is 50 and the standard deviation is 20.

Page 2

NAME #113 CLASS OR UNIT _____ RATED BY _____ DATE _____
(or identification number)



PROFILE SHEET

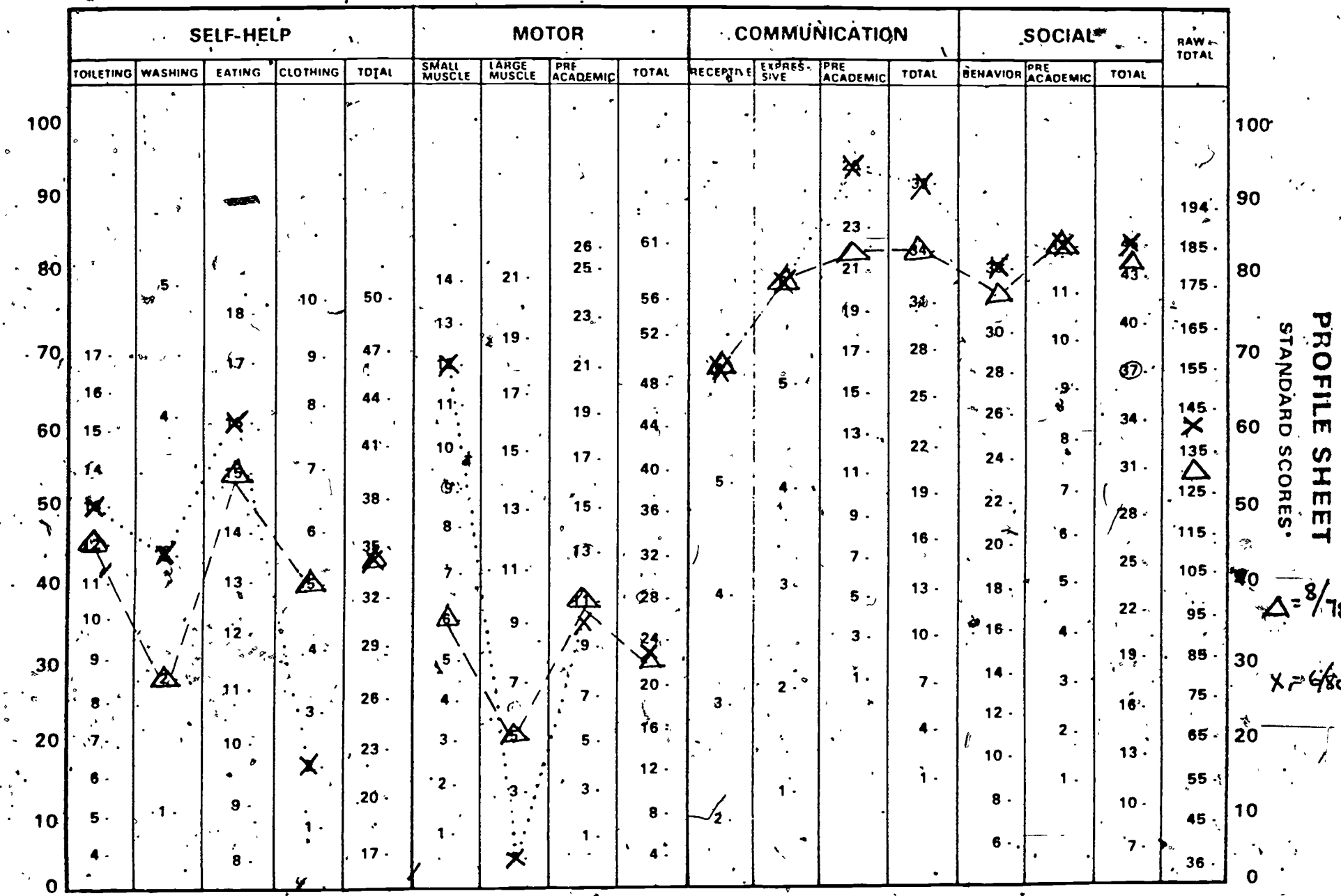
STANDARD SCORES*

△ = 8/78

X = 6/80

*Standard scores here are adjusted so that the mean score is 50 and the standard deviation is 20.

NAME #183 CLASS OR UNIT _____ RATED BY _____ DATE _____
(or identification number) *



*Standard scores here are adjusted so that the mean score is 50 and the standard deviation is 20.

Appendix D:

Revised Parent Interview Schedule

PARENT INTERVIEW

Child's Name: _____ Interviewer: _____

Date: _____

Directions to the Parents

The Appalachia Educational Laboratory is evaluating the effectiveness of the Shawnee Hills Homebound Program for Orthopedically Handicapped Children. Because it is a homebound program, it is important for us to learn about each child's home environment in order to understand if involvement in the program has any effect on it. We would also like to learn how parents feel about the program so that their feelings are represented in the evaluation report.

I would like to ask you some questions about your daily routine and about the Shawnee Hills Program. Everything that you say will be confidential; only AEL staff will read or hear your answers. In addition, if you cannot comfortably answer any of the questions, please tell me and we'll go on to the next question.

1. Will you agree to participate in the evaluation interview? Yes ___ No ___. (If yes) Thank you. We will want to ask you some of these questions again in about six months to see how things are going for you then.

Do you have any questions?

Part I

Twenty-four Hour Recall

Directions to the mother (or caregiver):

I would like to learn more about how _____ spends (his/her) days, and what goes on around (him/her). I would like for you to concentrate on yesterday. Was yesterday a fairly typical day in your home? ___ Yes ___ No. (If yes, proceed.) I'd like for you to tell me about your day: Especially try to remember things that you did and things that _____ (child's name) _____ did. I may ask you questions as you talk to try to help you remember some of the specific events. Try to tell me everything that you did as if it were the script for a movie.

Do you mind if I record your story? It helps me to be able to listen to you more closely if I don't have to write. ___ Yes ___ No.

It is easier to remember if we go through the day from the beginning. If you leave something out and remember it later, just tell me. Do you have any questions?

How did the day start? Who was the first one awake in the morning?

(Throughout the mother's recall of the preceeding day, the interviewer should concentrate upon those events which: (1) detail the child's activities, (b) lasted for at least 10-15 minutes, (c) identifies those persons who interacted with the child.)

Part II

Directions to the Parent:

Now I'd like to ask you some questions about activities that you may be involved in and about how you feel about the Shawnee Hills Program that your child is involved with.

1. Do you receive a daily newspaper? ___ Yes ___ No Who reads it? _____

2. Are you a member of any social or religious organizations? ___ Yes ___ No

3. (If yes) Which ones? _____

4. How about any other members of your family? ___ Yes ___ No

5. If the answer to 4 is "yes," list name of family member and what club or organization (he/she) is involved with:

Name	Organization

6. How long have you lived here? ____ years

7. Has your family ever been on trips outside of the county? ___ Yes ___ No

7a. (If yes) Where did you go and who went? _____

8. Do you have any relatives or friends who live close by or who you visit with on a regular basis? ___ Yes ___ No

8a. (If yes) Who are they and about how often do you get a chance to visit with them?

9. What agencies have you been involved with in the past to try to get services/help for your child? _____

10. What services/help did you receive from them? _____

11. Were you satisfied or dissatisfied with the help that you got? _____

Why? _____

12. How did you hear about the Shawnee Hills Orthopedic/Handicapped Program?

_____

_____

13. What would you like to see your child accomplish in the future? (related to the program or perhpas not related to the program)

_____

_____

14. What things do you expect that your child will accomplish over the next year?

_____

_____

15. Do you have any plans for your child for the future? ___ Yes ___ No

If yes, what are they? _____

_____

_____

Ask questions 16-21 for post-test only

The next few questions relate specifically to the Shawnee Hills Homebound Program.

16. What do you like best about the Shawnee Hills Program for your child?

_____

_____

_____

17. What don't you like about the program? _____

_____

18. Do you think the "home trainer" approach is the most effective method for helping your child? ___ Yes ___ No

Why? _____

_____

19. How have you participated in the homebound program?

20. As a parent of a handicapped child, have you benefited and learned from the program? ___ Yes ___ No (Seek elaboration on what the parent has learned or not learned)

21. Do you have any suggestions or ideas for improving the Shawnee Hills Program?

Appendix E:

Parent/Home Environment Evaluation Form

Home Visitor Completing Form: _____

PARENT/HOME ENVIRONMENT EVALUATION

Instructions to the Home Trainer:

The parent evaluation is designed to provide information about the client's background and current home environment. It is to be completed one month after enrollment in the Orthopedic Homebound Program and again at six-month intervals by the home visitor who is the most familiar with the home and family. The purpose of the evaluation is to provide some measure of change in the quality of stimulation available to the client.

If some of the information is unknown, leave the answer blank and try to determine the information informally in conversation with the child's primary caregiver.

Where there is room to write comments, please try to explain the reasoning behind your answer. Give specific examples as often as you can.

Part I

1. Name of child in program _____

2. Age _____ 3. Sex _____ 4. Number of siblings by sex ____ M ____ F

5. Ages of siblings ____ ____ ____ ____ ____ ____ ____

6. Father's occupation _____

   a. educational level, if known _____

7. Mother's occupation _____

   b. educational level, if known _____

8. Father's age _____ 9. Mother's age _____

10. Approximate income level:
    - ___ Under $6,000
    - ___ $6,009 - $10,000
    - ___ $10,000 - $14,000
    - ___ Over $14,000

11. Has this income level been fairly constant over the last five years?

    _____ Yes _____ No

    If no, briefly explain: _____

12. Does the family own their home? ____ Yes ____ No

13. Who lives in the home with the child?

____ Mother If not, reason: _____

____ Father If not, reason: _____

____ Number of siblings

Others (name and relationship to child)

_____ _____

_____ _____

14. Who is the primary caregiver? _____

Part II

Child's Name _____ Home Trainer: _____

1. Does the handicapped child stay in one room or one part of the house the major part of the waking hours (60% or greater)?

   ____ Yes ____ No

   Comments: _____

2. Does the mother (or caregiver) arrange the child's location in the house in order that contact (vocal and/or visual) can be maintained throughout the day?

   ____ Always ____ Usually ____ Sometimes ____ Rarely ____ Never

   Comments: _____

3. When speaking about the child, does the mother (or caregiver) typically convey positive feelings? (This would include statements of concern, love, of the child being "her boy" or "her girl" implying endearment.)

   ____ Always ____ Usually ____ Sometimes ____ Rarely ____ Never

   Examples: _____

4. Does the mother (or caregiver) caress, pat, hug, or kiss the child?

   ____ Always ____ Usually ____ Sometimes ____ Rarely ____ Never

   Comments: _____

5. Does the mother (or caregiver) talk to the child throughout the course of the day?

   ____ Always ____ Usually ____ Sometimes ____ Rarely ____ Never

   Comments: _____

6. Does the mother (or caregiver) try to maintain eye contact with the child when talking to him/her?

   ____ Always ____ Usually ____ Sometimes ____ Rarely ____ Never

   Comments: _____

7. Does the child usually eat with other family members?

_____ Yes _____ No _____ Sometimes

Comments: _____

_____

8. Does the child have any books or magazines near enough to easily reach?

_____ Yes _____ No

Comments: _____

_____

9. Are there pictures, posters or other decorative items in the child's room?

_____ Yes _____ No

Comments: _____

_____

10. Does the child have toys, games, or stuffed animals to play with?

_____ Yes _____ No

Comments: _____

_____

11. Does the mother or some other member of the immediate family read or tell stories to the child (in addition to those suggested by home visitor)?

_____ Yes _____ No

If yes, how often? _____

12. How much time does the child watch TV? (Include the number of hours spent in front of a television set.)

_____ Hours/day

Comments: _____

_____

13. Does the child sleep in a room with other siblings or family members?

_____ Yes _____ No How many occupy the same room? _____

Comments: _____

_____

14. Is the child taken on trips outside the house?

_____ Daily
_____ At least twice a week
_____ At least once a week
_____ At least once a month
_____ Less than once a month

Comments: _____

_____

15. If weather allows, is the child taken outside the house for yard play? Or, if unable to participate, to observe?

_____ Daily
_____ At least twice a week
_____ At least once a week
_____ At least once a month
_____ Less than once a month

Comments: _____

_____

16. (If the father is in the home) Does the father have daily active contact with the child?

_____ Yes _____ No

Describe: _____

_____

17. Does the mother (or primary caregiver) generally try to promote self-care/self-help habits with the child? (This includes feeding, dressing, washing, combing hair, etc.)

____ Always ____ Usually ____ Sometimes ____ Rarely ____ Never

Comments: _____

_____

18. Does the mother (or primary caregiver) carry out physical excercises and lessons presented by the physical therapist and home visitor?

____ Always ____ Usually ____ Sometimes ____ Rarely ____ Never

Comment on level of involvement/interest: _____

_____

_____

19. Are the mother's expectations of what the child will be able to do realistic (in keeping with the child's capabilities and potential)?

_____ Yes _____ No

Comments (give specific examples if possible): _____

_____

_____

20. Does the mother use appropriate discipline techniques with her handicapped child?

_____ Yes _____ No

Comments (give specific examples or problem areas): _____

_____

_____

Appendix F:

Newspaper Story

Happy Miracle

Medicine, Therapy Program Giving Double-Handicapped Child A Future

By NANYA GADD
Of The Daily Mail Staff

GREENWOOD — He smiles. He babbles. He laughs out loud.

That may sound less than earth-shattering, but it's nothing short of a miracle for the family of Mark Johner, 9.

Asked about her youngest child's future, Mrs. Cathy Johner says, "I think he has one now."

Mark has cerebral palsy and is profoundly mentally retarded. Until several months ago, he often experienced severe epileptic seizures that would send his tiny body into rigid "extension."

The draining episodes left the small boy vulnerable to any passing infection. His permanent handicaps often were complicated by colds, flu or other illness.

But Mark had one factor working to his advantage. The Johner family simply refused to give up on the frail blue-eyed wisp of a child.

About two and a half years ago, Mark became a student for the first time in his life. With his muscle control no better than a newborn infant's, he was enrolled in an experimental new program at Shawnee Hills Regional Mental Health/Mental Retardation Center.

A worker in the Orthopedic Homebound Program began to visit Mark's Boone County home each week. A variety of other professionals, including a physical therapist and a child psychologist, evaluated his progress regularly.

One of the first changes brought something unprecedented to the Johner household — a full night's sleep. Mark had always slept fitfully, often waking and crying. Believing he was in pain, his parents would go to him.

The psychologist theorized that Mark had developed a habit simliar to that of a spoiled newborn's. The Johners were instructed to first ensure that Mark was not sick, then let him cry. It worked, and Mark has slept soundly through the night ever since.

By last spring, he had made considerable progress through the Shawnee Hills program. He was learning to control his head and neck muscles and could follow his parents with his eyes. Then a setback occurred.

His seizures began to occur more frequently. No sooner would he recover from the exhaustion of one seizure than another would begin. At one point, Mark's mother was feeding him with a medicine dropper as he passed from drained sleep to seizing wakefulness. Always thin, he lost even more weight.

Mark's doctor was pessimistic but decided to try increasing the dosage of the medicine that was supposed to control the seizures. It worked.

"I guess he had just outgrown the dosage," Mrs. Johner said.

The change in the ensuing months has been dramatic. Mark is healthier than he has ever been in his life. His weight has nearly doubled, and he is responding more than ever to Margaret Payne, the Shawnee Hills worker who visits him twice each week.

The federally funded program is due to expire in June, but the Johners have been trained to work with Mark themselves. Mrs. Johner is confident that he will continue to improve.

She laughs about the fact that he dislikes liver now. "That tickled me because none of the other kids like it. Now Mark does something they do."

Mark also attends church now and can go shopping with his mother in a specially designed wheel chair Mrs. Johner said:

"There for a while I didn't look from one day to the next Now I can If I have to go somewhere, I can take Mark with me. I can look forward to tomorrow"

HOME TRAINER MARGARET PAYNE WORKS WITH MARK
Handicapped Child Is Responding To Program

3-26-80 Daily Mail Photo by Chet Howes

Appendix G:

Quarterly Report Analysis Form (QRAF)
Completed with Third Year Data

Orthopedic Homebound Program (OHP)
Shawnee Hills Regional Center, Inc.

AEL Project Evaluation

Quarterly Report Analysis Form (QRAF) (new version)

Data Categories / Quarterly Report Numbers and Dates and Data Totals	QR #1 7/1/79 to 9/30/79	QR #2 10/1/79 to 12/31/79	QR #3 1/1/80 to 3/31/80	Total Number (if app.)	Average Number (if app.)
1. Client Data					
A. Number of referrals received	1	1	0	2	.67
B. Number of intake evaluations	0	1	0	1	.33
C. Number of other evaluations	0	5	17	22	7.33
D. Number of cases managed	9	8	7	25	8.33
E. Number of cases closed	1	0	0	1	.33
I. Number of on-site visits	167	160	187	514	171.33
J. Number of special therapies	0	0	17	17	5.67
M. Number of service transfers	0	0	1	1	.33
N. Number of referred externally	1	0	0	1	.33
V. Number of support activities	0	0	0	0	0
W. Number of recreation	NR	NR	0	0	0
Y. Number of psychologicals	NR	NR	0	0	0
2. Client Data Expanded					
C. Other evaluations detailed					
(1) Nutritional	5	NR	NR	5	NA
(2) Developmental	1	1	NR	2	1
(3) Visual	1	NR	NR	1	NA
(4) Speech/language	6	1	4	11	3.67
(5) Phsyical therapy	6	1	6	13	4.33

Data Categories \ Quarterly Reports and Totals	QR #1 7/1/79 to 9/30/79	QR #2 10/1/79 to 12/31/79	QR #3 1/1/80 to 3/31/80	Total Number (if app.)	Average Number (if app.)
2. Client Data Expanded (continued)					
C. Other evaluations detailed (continued)					
(6) Occupational therapy	9	1	5	15	5.00
(7) Nurse	NR	NR	2	2	1
D. Cases managed					
(1) Cindi Deese	NR	8	7	15	7.5
I. On-site visits					
(1) Cindi Deese	24	30	32	86	28.67
(2) Robin Millstone	78	89	83	250	83.33
(3) Barb Henry	34	NR	NR	34	N/A
(4) Fred Theirel	7	NR	NR	7	N/A
(5) Lisa Hicks	6	NR	NR	6	N/A
(6) Janet McAdoo	11	NR	NR	11	N/A
(7) Linda Powers	4	NR	NR	4	N/A
(8) Brenda McBrayer	2	NR	2	4	2
(9) Margaret Payne	NR	41	70	111	55.5
J. Special therapies					
(1) Speech therapist	NR	2	NR	2	N/A
(2) Physical therapist	NR	7	NR	7	N/A
(3) Occupational therapist	NR	7	NR	7	N/A
(4) Nurse	NR	2	NR	2	N/A

Data Categories / Quarterly Reports and Totals	QR #1 7/1/79 to 9/30/79	QR #2 10/1/79 to 12/31/79	QR #3 1/1/80 to 3/31/80	Total Number (if app.)	Average Number (if app.)
II. Staff Activity Summary					
A. Progress towards making the goals					
(1) Evaluation activities with AEL	1	1	2	4	1.33
(2) Secondary prevention activities	1	1	1	3	1
(3) Number of additional staff training materials acquired each quarter	1	NR, but see #22	1 N = 21	2	.67
(4) Specific staff training topics mentioned--number of topics	1 N = 4	1 N = 5	NR	2 9	.67 4.5
(5) Parent newsletters go out monthly	1	1	1	3	1
(6) National presentations mentioned	1	1 N = 2	1	3	1
(7) OHP sign is mentioned	1	1	NR	2	.67
(8) Advisory board members/ activities are named	1	NR	1	3	1
(9) Slide presentation mentioned	1	NR	1	2	.67
(10) Consultation services to families is mentioned	1	1	1	3	1
(11) Deliverable products (handbooks) are mentioned	2	1	2	5	1.67
(12) Comprehensive services to clients is mentioned	1	1	1	3	1
(13) Program continuation explored	1	1	1	3	1

Data Categories / Quarterly Reports and Totals	QR #1 7/1/79 to 9/30/79	QR #2 10/1/79 to 12/31/79	QR #3 1/1/80 to 3/31/80	Total Number (if app.)	Average Number (if app.)
II. Staff Activity Summary (continued)					
A. Progress towards making the goals (continued).					
(14) Cooperative arrangement discussions with Colin Anderson Center	1	NR	1	2	1
(15) Client and program data and/or record keeping (MIS) mentioned	1	NR	2	3	1.5
(16) "Orthopedic Homebound Service Update" publication mentioned	1	NR	1	2	1
(17) Contractual and cooperative arrangements for clients mentioned	1	NR	1	2	1
(18) Job description revisions mentioned	1	NR	NR	1	N/A
(19) Parent service plan mentioned	1	NR	NR	1	N/A
(20) Parent seminar discussed	NR	NR	1	1	N/A
(21) Technical assistance contractor mentioned	NR	1	1	2	1
(22) Resource library for staff and parents is mentioned	NR	1 --- Items = 12	1	2	1
(23) Training grant to dev. disb. was mentioned	NR	NR	1	1	N/A
(24) CPC time devoted to WV system is outlined	NR	NR	1	1	N/A

Data Categories / Quarterly Reports and Totals	QR #1 7/1/79 to 9/30/79	QR #2 10/1/79 to 12/31/79	QR #3 1/1/80 to 3/31/80	Total Number (if app.)	Average Number (if app.)
II. Staff Activity Summary (continued)					
A. Progress towards making the goals (continued)					
(25) OHP Director designs staff development for children's MR program	NR	NR	1	1	N/A
(26) Newspaper article named	NR	NR	1	1	N/A
B. Efforts towards public education, prevention, etc.					
(1) Person hours per quarter	480	480	480	1440	480
(2) Number staff x quarter person hours	3 x 1440 + 1 (2 mo) staff	4 x 480	4 x 480		
(a) Product of (2) above	1764	1920	1920	5604	1868
(3) 10% of total program hours equal	176.4	192	192	560.4	186.8
(4) (a) Summary statement, re: projected hours exceeded or not for secondary prevention	hours were exceeded	hours were exceeded	hours were exceeded	in all 3 report periods the hrs. were exceeded	N/A
(b) Number of hours devoted to community awareness	500 hours	100 hours for nat. meetings 30 hours	52 hours	682	227.33
(c) Number of hours devoted to case consultation/quarter	NR	NR	96	96	N/A
C. Progress towards meeting direct service goals for professionally trained supervisory and supportive staff					
(1) Percent of program directors time devoted to direct service	25% (120 hrs)	25% (120 hrs)	25% (120 hrs)	25% each report period (360)	N/A (120)

Data Categories / Quarterly Reports and Totals	QR #1 7/1/79 to 9/30/79	QR #2 10/1/79 to 12/31/79	QR #3 1/1/80 to 3/31/80	Total Number (if app.)	Average Number (if app.)
II. Staff Activity Summary (continued)					
C. Progress towards meeting direct service goals for professionally trained supervisory and supportive staff (continued)					
(1) (a) Number of hours PD spent in home visits	20 hours	120: full 25% named above	16	156	52
(b) Number of hours PD spent in stimulation packets for parents	60 hours	30 hours	NR	90	45
(c) Number of hours PD spent on developing parent handbook	NR	NR	40	40	N/A
D. Progress towards meeting program staff development goals					
(1) Center inservices or training					
(a) Number of different sessions named	4	Note: national confer. were included in earlier figure 3	4	11	3.67
(b) Total number of staff attending all sessions named	7	7	4	18	6
(c) Total inservice hours generated this quarter (total staff x number hours each session)	assuming 2 hours each, then: 14	actual hours given 24	28	66	22
(2) Program staff enrolled in sponsored college courses					
(a) Total number of staff named as in college courses	2	2	2	6	2

Data Categories / Quarterly Reports and Totals	QR #1 7/1/79 to 9/30/79	QR #2 10/1/79 to 12/31/79	QR #3 1/1/80 to 3/31/80	Total Number (if app.)	Average Number (if app.)
II. Staff Activity Summary (continued)					
D. Progress towards meeting program staff development goals (continued)					
(2) (b) Total number of college credits by all staff this quarter	12	9	9	30	10
(3) Workshops or seminars attended by staff					
(a) Total number of workshops or conferences attended by staff	None	2	3	5	2.5
(b) Total number of staff attending workshops or seminars this quarter	None	3	4	7	3.5
(4) Computation of staff development person hours compared to goal set					
(a) Fulltime staff this quarter	3	4	4	11	3.67
(b) Number of staff development hours which should be generated this quarter	144	192	192	528	176
(c) Number of hours spent in center inservice training	29	42	52	123	41
(d) Number of hours spent in college courses	144	108	108	360	120
(e) Number of hours spent in workshops/seminars	0	104 (national)	104	208	104

Data Categories / Quarterly Reports and Totals	QR #1 7/1/79 to 9/30/79	QR #2 10/1/79 to 12/31/79	QR #3 1/1/80 to 3/31/80	Total Number (if app.)	Average Number (if app.)
II. Staff Activity Summary (continued)					
D. Progress towards meeting program staff development goals (continued)					
(4) (f) Total number of staff hours	179	254	264	697	232.33
(g) Staff development goal hours minus item (b) above	29	62	72	163	54.33
E. Personnel Information					
(1) Number of full time staff this quarter	3	4	4	11	3.67
(2) Number of part time staff this quarter	0	0	0	0	0
(3) Program vacancies					
(a) Number of vacancies	1	0	0	1	N/A
(b) Length of time of vacancy	1 month	N/A	N/A	1 month	N/A
(4) Number of staff employed this quarter					
(a) Position filled	1 home trainer	N/A	None	1	N/A
F. Program revenue					
(1) Income generated through Title XX	"Total Income"	"Total Income"	"Total Income"	"Total Income"	N/A
(2) Number of program clients provided this quarter	9	8	8	25	8.33

Special Notes: NR = Not Reported
N/A = Not Applicable

Appendix H:

Sample OHP Monthly Newsletters

Orthopedic Homebound Monthly Newsletter

AUGUST 1979

MEDICATION SHEET FOR CHILDREN

ACETOMINOPHEN
This medication relieves pain and reduces fever.

Medication name	Age of child	Amount to give	How often
Liquiprin®	2 mo. to 6 mo.	0.3 to 0.6 on dropper or up to 1/8 teaspoon	no sooner than,
	6 mo. to 1 yr.	0.6 to 1.2 on dropper or 1/8 to 1/4 teaspoon	every four hours
	1 yr. to 3 yr.	1.2 to 2.4 on dropper or 1/4 to 1/2 teaspoon	"
	3 yr. to 6 yr.	2.4 on dropper or 1/2 teaspoon	"
Tempra® drops or	2 mo. to 6 mo.	0.3 on dropper	"
Tylenol® drops	6 mo. to 1 yr.	0.3 to 0.6 on dropper or up to 1/8 teaspoon	"
	1 yr. to 3 yr.	0.6 to 1.2 on dropper or 1/8 to 1/4 teaspoon	"
Tempra® elixer,	6 mo. to 1 yr.	1/2 teaspoon	"
Tempra® syrup,	1 yr. to 3 yr.	1/2 to 1 teaspoon	"
Tylenol® elixer, or	3 yr. to 6 yr.	1 teaspoon	"
Datril® elixer	6 yr. to 12 yr.	2 teaspoons	"
Tylenol® tablet	3 yr. to 6 yr.	1 tablet	"
(120 mg)	6 yr. to 12 yr.	2 tablets	"

CHILDREN'S ASPIRIN
This medication relieves pain, reduces fever, and reduces swelling or inflammation.

Medication name	Age of child	Amount to give	How often
Tablet (1/2 grain)	2 mo. to 6 mo.	1/2 tablet	no sooner than
Hylands	6 months	1 tablet	every four hours
	1 year	2 tablets	"
Tablet (1 1/4 grains)	1 yr. to 10 yr.	general rule: 1 grain per year of age	"
St. Joseph, Bayer, or Hylands			

If a marked dropper doesn't come with the liquid medication, please use your kitchen measuring spoons for accuracy. The above amounts may need to be adjusted if your child is overweight or underweight for his age and we will be happy to advise you.

REMEMBER these medications do NOT cure the common cold or any other illness. Their function is only to relieve symptoms as listed above. If in any doubt please consult with us before giving any of the above medications if we have suggested that your child should use them. Keep these and all medications out of any child's reach as they are all potential poisons if taken in an overdose.

References

Baker C E: Physicians Desk Reference, 31st Edition. Oradell, N.J., Medical Economic Company, 1977.

Jacobs R A: Childrens Hospital of Los Angeles Resident Manual, Fourth Edition, Los Angeles, Calif., 1975, Sec. XVIII-2.

Manufacturers eyedropper and standard kitchen measuring spoons were used to determine equivalents.

THE AMERICAN RED CROSS ATTACKS POISONS

IS IT POISON?

Symptoms vary greatly. Base your suspicion that a person has swallowed poison on—

- Information from the victim or an observer
- Presence of a poison container
- Sudden onset of pain or illness
- Burns around the lips or mouth
- Chemical odor on the breath
- Pupils contracted or dilated

FIRST AID FOR POISON BY MOUTH

Conscious victim:

- *Dilute* the poison *with a glass of water or milk* if the victim is not having convulsions.
- *Call the poison control center* or your doctor or dial 0 or 911; call the emergency rescue squad.
- Save the label or container for identification; save vomited material for analysis.
- *Do not* neutralize with counteragents. *Do not* give oils
- If the victim becomes unconscious, keep his airway open.

Unconscious victim:

- Maintain an open airway
- Call the emergency rescue squad.
- Give mouth-to-mouth resuscitation or cardiopulmonary resuscitation (CPR) if necessary
- *Do not* give fluids, *do not* induce vomiting, if the victim is vomiting, position his head so that vomit drains from his mouth
- Save the label or the container for identification; save vomited material for analysis.

Convulsions:

- Call the emergency squad as soon as possible.
- *Do not* attempt to restrain the victim, try to position him so that he will not injure himself.
- Loosen tight clothing.
- Watch for obstruction of the airway and correct it by tilting the head; give mouth-to-mouth resuscitation or CPR if necessary.
- *Do not* force a hard object or finger between the teeth.
- *Do not* give any fluids.
- *Do not* induce vomiting

After a convulsion, turn the victim on his side or in the prone position, with his head turned to allow fluid to drain from his mouth.

Instructions on product labels for specific treatment of poisoning *may* be wrong; contact your doctor or a poison control center for instructions.

Have on hand

These products should be used *only* on the advice of your doctor or the poison control center.

1. *Syrup of ipecac* (to induce vomiting)
2. *Activated charcoal* (to bind, or deactivate, poison)
3. *Epsom salts* (a laxative)

If poisoning occurs where medical help is unavailable (e.g., camping), you may induce vomiting if the victim has taken an overdose of drugs or medication, but not if a strong acid, alkali, or petroleum product has been swallowed. Then get the victim to a hospital as quickly as possible.

Emergency telephone numbers

DOCTOR 348-4211

RESCUE SQUAD 345-2558

POISON CONTROL CENTER _____

Write in these numbers now! Have the family memorize them. Also place them on your telephone

The information on this poster is based on a report prepared by the National Academy of Sciences—National Research Council Committee on Emergency Medical Services.

Poison prevention practices can eliminate needless illness and worry. Call your Red Cross chapter to enroll in a first aid course.

When most people think of poisoning, they think of arsenic or strychine. But it's the more common things, like aspirin and cleaning products that parents often don't realize hazarads, too.

For example, youngsters and adults alike have been poisoned by moth balls, cosmetics, vitamins, deoderants, soaps, broken plaster, houseplants and a host of other - products that are commonly found in any home.

* Read lables and precautionary statements on all containers.

* Store potentially harmful products and drugs out of the reach of children.

* Keep products in their original containers. Transferred to soda bottles, milk cartons, etc., they can tempt or confuse.

* Don't keep edibles and non-edibles stored together.

* Drugs - the most common poison - should be stored high above a child's reach or, if possible, in locked cabinets. Never call medicine "candy." and never take medicine in the dark or in front of children.

* If you are distracted while using a household product or drug, take it with you. Don't leave it out for a child to reach.

* Know which of your houseplants and outdoor shrubbery plants are poisonous and keep children away from them.

* Have the nunbers of your physician and poison control center handy.

Orthopedic Homebound Monthly Newsletter

September 1979

THE AMERICAN NATIONAL RED CROSS

FIRST AID FOR POISONING

1. Call your nearest poison control center, family Physician, or hospital emergency room

2. Make poison victim vomit if directed* but do not induce vomiting if victim has ingested corrosive material, is unconscious or is convulsing.

3. Do not waste time waiting for vomiting, but transport victim, if indicated, to a medical facility. Bring with you the container(s) of the substance(s) involved. If vomiting occurred, bring the vomited discharge.

*It is recommended, using as directed, syrup of ipecac to induce vomiting - this is available at your local drugstor.

HINTS ON DRESSING

Some children will be able to learn self-help skills at a faster rate than others. You will also find that some children can accomplish parts of skills, but they will need training to complete the task.

To begin, see how much your child can do already, where she/he falters is where we begin training. Let your child observe the task, demonstrate it for him, if he can imitate, let him complete the task. Remember to teach each child at his own rate of learning.

Another good thing to keep in mind while teaching dressing is to begin at the end of the task and reinforce/reward big! An example of this backward chaining would be if you are teaching removal of shirt, trainer takes it all the way off except letting it hang loosely on his arm and say "Johnny, take off your shirt". SUCCESS - REWARD - PRAISE! "Good taking your shirt off Johnny!". Gradually, after he has mastered this step in the skill, leave the shirt a little higher on his arm, etc. In the beginning the child will need a lot of going over the task, he might not understand at first, so go slow . . . showing him how proud you are even after the littlest effort will keep him trying and both of you pleased with your success.

Barb Henry

INTRODUCTION
SENSORY STIMULATION

Let's think a moment about a child who can move around normally. He creeps on the carpet; he touches a hot stove; his dad tosses him up in the air. All of these activities are types of sensory stimulation. In many cases, the parents of a child who is having some type of problem are so protective that the child misses out on much of the normal sensory stimulation. This is compounded by the fact that the child cannot move about independently.

Why is sensory stimulation so important? It is important in the development of the brain. The brain is like a computer--you must put information into it, before you can expect to get anything out of it. Sensory stimulation is one very important method by which you can put information into the brain.

Let's take a look at what happens when a child touches a hot stove. Receptors in the skin are affected by heat. They send this information along the nerves, into the spinal cord, then up to the brain. The brain does several things with this information:

1) It sets up cycles in the brain, which are used to store the information that the "stove is hot."

2) It determines what action to take. In this case, the brain would send impulses back down through the spinal cord, out the nerves, to the muscles. This impulse causes the muscles to contract, which causes the arm to pull away.

Think for a minute--you don't have to touch a burner to know that it's hot. Why not? Because your "computer" has been fed the information (by past experience) and has stored it to be used in the future.

Therefore, the more sensory stimulation the child experiences, the more information he has stored in the brain to use for complex thinking processes.

Appendix I:

Newsletter Evaluation Questionnaire (NEQ)

Orthopedic Homebound Program (OHP)
Shawnee Hills Regional Center, Inc.

AEL Project Evaluation
Newsletter Evaluation Questionnaire (NEQ)

Introduction: The purpose of this questionnaire is to provide parents with an opportunity to help evaluate the monthly newsletter. Please answer the following questions carefully. Please leave no blanks.

1. How long has your child been in the Orthopedic Homebound Program? _____ Years

2. How many Orthopedic Homebound Monthly Newsletters have you received? _____

3. Do you like the monthly Newsletter? Circle the answer which best expresses your feeling.

   Yes, Very Much Yes OK No No, Not At All

4. Do you save your monthly Newsletters? Circle your answer.

   Yes No

5. Did you read the whole Newsletter each time it comes? Circle your answer.

   Yes No

6. Have you found useful information in the Newsletter? Circle your answer.

   Yes No

7. Is the Newsletter content too technical for you? Circle your answer.

   Yes No

8. Have you performed any of the Newsletter activities with your child? Circle your answer.

   Yes No

9. How would you rate the overall quality of the Newsletter? Circle the answer which best expresses your feeling.

   Excellent Good OK Poor Very Bad

10. Have you ever written to or telephoned any of the organizations, agencies, or persons listed in the Newsletter? Circle your answer.

    Yes No

11. Other comments or concerns?

Appendix J:

Parent Handbook Evaluation Questionnaire (PHEQ)

Orthopedic Homebound Program (OHP)
Shawnee Hills Regional Center, Inc.

Parent Handbook Evaluation Questionnaire

Directions: The enclosed document is a draft of a handbook for parents of severely impaired/mentally retarded children or youths. Your assistance in evaluating this draft document is solicited. Please complete and return the evaluation form with your comments. Your cooperation and comments are appreciated.

1. Please check your present role: ☐ Parent, ☐ Student, ☐ Teacher, ☐ Administrator, ☐ Higher Education, ☐ Other _____.

2. How many years of teaching experience do you have? _____ years.

3. What is your overall rating of the value of this document on the following scale?

Low Value			Average Value			High Value		
1	2	3	4	5	6	7	8	9

4. What material(s) or section(s) did you find most helpful or useful?

5. What material(s) or section(s) did you find least helpful or useful?

6. What areas do you think should be added or expanded? Give specific examples, if you can.

7. What did you think about the organization or format of the draft? Do you have any suggestions for improvement?

8. Other comments, thoughts, or suggestions for improving the handbook:

OPTIONAL:

Your Name: _____

Address: _____

City, State, Zip: _____

RETURN TO:

Merrill L. Meehan
Appalachia Educational Laboratory
Post Office Box 1348
Charleston, WV 25325

Appendix K:

Presentation Evaluation Form (PEF)

Orthopedic Homebound Program (OHP)

Shawnee Hills Regional Center, Inc.

Presentation Evaluation Form (PEF)

Introduction: The purpose of this questionnaire is: (1) to provide feedback to presentors for improvement of future sessions, and (2) document what transpired for our funding agency. Please respond to all items: leave no blanks. Thank you.

I. A. Please check the job function which consumes 51 percent of your working time.

☐ Parent ☐ Supervisor ☐ Social Worker

☐ Teacher ☐ Administrator ☐ Services (e.g. Therapist)

☐ Other (Specify): _____

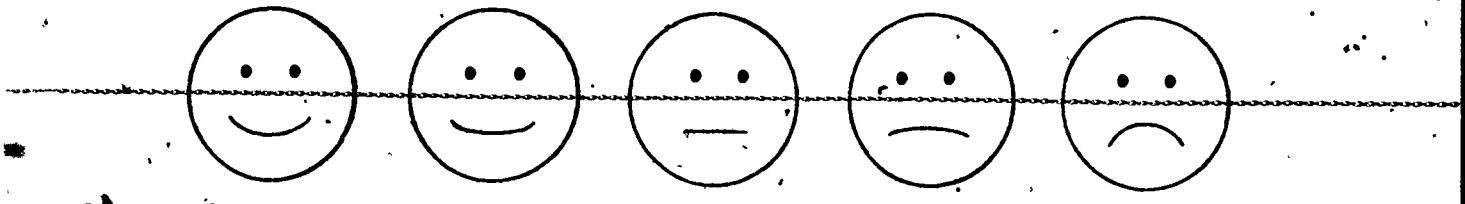
B. Name one strength of this session: _____

_____

II. Presentation Components - Rate the following presentation components on a scale of 5 (Highly Effective) to 1 (Ineffective) by circling your choice.

A.	Development of the Orthopedic Homebound Program (OHP)	5	4	3	2	1
B.	Orthopedic homebound model	5	4	3	2	1
C.	Description of OHP services	5	4	3	2	1
D.	Evaluation of the OHP	5	4	3	2	1

III. A. Overall Evaluation - Please circle or otherwise mark the face corresponding to your overall feeling about this presentation session.



B. In the space below or on the back, please write any personal reactions or comments which you feel are important in terms of assessing the value and content of this presentation.

_____

_____

_____

_____

Mail to: Merrill L. Meehan, Appalachia Educational Laboratory, P. O. Box 1348, Charleston, West Virginia 25325

Appendix L:

Seminar Announcement Flyer
and Detailed Agenda

June 5-6, 1980

Please print or type

Serving the Severely Handicapped:
A Seminar for Parents and Professionals.

NAME: _____ ☐ I will require parking space

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: _____ EMPLOYER: _____

MAIL REGISTRATION AND FEES TO:
Severely Handicapped Seminar
Division of C&E
Shawnee Hills CMH/MRC Inc.
1212 Lewis Street Suite 305
Charleston, W.V. 25301

MAKE CHECK PAYABLE TO: Shawnee Hills
Workshop Fee: $15.00 person; $20.00 per couple
Students - Half Fee: $7.50
Thursday Evening Only $4.00

TOTAL ENCLOSED _____

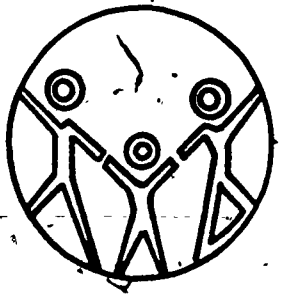
SHAWNEE HILLS COMMUNITY MH/MR CENTER, INC.

Shawnee Hills Community MH/MR Center
Division of Consultation & Education
1212 Lewis Street
Charleston, West Virginia 25301

June 5-6, 1980 Charleston, W.Va.
WVU Medical Education Building

Serving the Severely Handicapped

A Seminar for Parents and Professionals



Legal Issues
Future Planning
Self-Help Skills
Medical Issues

Family Counseling
Neurodevelopmental
Techniques

Agenda

June 5th, Thursday

1:00 - Welcome - Introductions - Brenda McBrayer,
Project Director, Orthopedic Homebound Program,
Shawnee Hills Community MH/MR Center

Film - "A Different Approach"

1:15 - **"Self-help Skills for the Severely Handicapped"**
Cynthia Liptak, Licensed Occupational Therapist trained in Neurodevelopmental Techniques. The Children's Hospital Medical Center of Akron, Akron, Ohio.
(Cindi currently works in two federally funded grant programs investigating the effects of early treatment in brain-damaged children.

2:30 - 6:00 **Concurrent Workshops** (Participants will be able to attend the three workshops on a rotating schedule.)

1. **"Neurodevelopmental Techniques."**
   Fred Theierl, Physical Therapist, Shawnee Hills Comm. MH/MR Center
2. **"Communication for the Severely Handicapped."**
   Lisa Hicks, Speech Pathologist, Shawnee Hills Comm. MH/MR Center
3. **"Media"** Sponsored by the W.Va. Advocates for the Developmentally Disabled.
   Films: "Sharing an Experience with Peter"
   "Who are the DeBolts?"
   "Failing to Learn: Learning to Fail."
   "Violation of Rights: P.L. 94-142
   "Get It Together"

6:00 Dinner (on your own)

7:30 - 9:00 **"Living with a Handicapped Child and Still Having a Happy Life."**
Vivian T. Harway, Ph.D. Clinical Psychologist/School Psychologist.
(Dr. Harway is a Clinical Professor of Child Psychology, University of Pittsburgh, and Director of C&E programs for the Pittsburgh Child Guidance Center)

June 6th, Friday

8:30 - Coffee & Doughnuts
9:00 - Forum: Legal Issues, Future Planning, Guardianship
10:30 - Break
11:00 - Forum: Medical and Financial Issues
12:00 - Lunch (on your own)
1:30 - 2:30 **"Parent Groups: What They Can Do"**
Glenda Davis, Parent of an 8-year-old child who has mental retardation, cerebral palsy, and epilepsy. Mrs. Davis also has five other sons. She is Program Coordinator of the Pilot Program, Greater Omaha Association for Retarded Citizens.

Serving the Severely Handicapped
Seminar for Parents and Professionals

West Virginia University Medical
Education Building
Charleston, West Virginia

Thursday, June 5, 1980

1:00 Welcome, Introductions:

Brenda McBrayer
Project Director, Orthopedic Homebound
Shawnee Hills Community MH/MR Center, Inc.

1:15 Self-Help Skills, Multi-sensory Stimulation for the Severely Handicapped

Cynthia Liptak, Licensed Occupational Therapist
The Children's Hospital Medical Center of
Akron - Akron, Ohio

2:30

Schedule A	Schedule B	Schedule C
"Neurodevelopmental Techniques: 2000 A+B Fred Theierl Physical Therapist Shawnee Hills Community MH/MR Center, Inc.	"Communication for the Severely Handicapped." 2044 A+B Lisa Hicks Speech Pathologist Shawnee Hills Community MH/MR Center, Inc.	Media-Auditorium (sponsored by WV Advocates for the Developmentally Disabled) "Sharing An Experience With Peter"

Schedule A	Schedule B	Schedule C
		"Who are the De Bolts?" "Failing to Learn: Learning to Fail" "Violation of Rights: P.L. 94-142" "Get it Together"
3:30 Coffee Break		
4:00 Media - Auditorium	Neurodevelopmental Techniques 2000 A+B	"Communication for the Severely Handicapped" 2044 A+B
5:00 "Communication for the Severely Handicapped" 2044 A+B	Media - Auditorium	Neurodevelopmental Techniques 2000 A+B

6:00 Dinner (on your own)

7:30 "Living with a Handicapped Child and Still Having a Happy Life"

Vivian T. Harway, Ph.D
Director of Consultation and Education
Pittsburgh Child Guidance Center
Pittsburgh, Pennsylvania

Friday, June 6, 1980

8:30 - Coffee and Doughnuts

9:00 - Forum: Legal Issues, Future Planning, Guradianship

Nancy Barnhart, Executive Director
Kanawha-Putnam Association for
Retarded Citizens

Gail Falk, Attorney
Appalachian Research and Defense
Fund, Inc.

Stuart May, Executive Director
West Virginia Advocates for the
Developmentally Disabled

10:00 - Break

11:00 - Forum: Medical and Financial Issues:

Ellen Cannon, Social Service Worker
WV Division of Handicapped Children

Barbara Williams
Social Security Administration

C.P. Wilson
WV Insurance Commission

12:00 - Lunch (on your own)

1:30 - "Parent Groups: What they Can Do"

Glenda Davis, Parent
Program Coordinator
Pilot Parent Program, Greater Omaha
Association for Retarded Citizens

Appendix M:

Seminar Evaluation Form (SEF)

Shawnee Hills Community MH/MR Center

Serving the Severely Handicapped:
A Seminar for Parents and Professionals

Seminar Evaluation Form

Directions: The purpose of this form is to provide feedback to presenters and organizers of the seminar. Thank you for responding.

A. Please check the box in front of the job function which consumes 51 percent or more of your working time.

☐ Parent ☐ Supervisor ☐ Nurse
☐ Teacher ☐ Social Worker ☐ Services (therapist)
☐ Other (specify) _____

B. Please indicate if you attended a session by marking the first box in the row. Next, please rate the effectiveness of each session attended on a scale of 1 (Very Ineffective) to 5 (Highly Effective) by marking one box from 1 to 5.

	Mark if you attended this session →	1	2	3	4	5
General Session I, Title: Self-Help Skills for the Severely Handicapped, Presenter: Cynthia Liptak						
Workshop 1, Title: Neurodevelopmental Techniques, Presenter: Fred Theirl						
Workshop 2, Title: Communication for Severely Handicapped, Presenter: Lisa Hicks						
Workshop 3, Title: Media (films)						
General Session II, Title: Living with a Handicapped Child and Still Having Life, Presenter: Vivian Harway						
Forum Number 1, Title: Legal Issues, Future Planning, Guardianship						
Forum Number 2, Title: Medical and Financial Issues						
General Session III, Title: Parent Groups: What They Can Do, Presenter: Glenda Davis						

C. Overall Rating:

Please circle or otherwise mark the face corresponding to your overall feeling about this seminar.